

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02932

2945

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>7 yrs. 9 mos. 25 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Maggie</b>	Middle <b></b>	Last <b>Addison</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>11,</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1864</b>
9. AGE (In years less birthday) <b>94</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	11. KIND OF BUSINESS OR INDUSTRY <b>-</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>John D. Addison</b>	14. MOTHER'S MAIDEN NAME <b>Martha Hendry</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Springfield Hospital Records</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO H2O.0			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile psychosis, simple deterioration.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>March 11, 1959</b> , that I last saw the deceased alive on <b>March 10, 1959</b> , and that death occurred at <b>8:40A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>	M.D.	DATE SIGNED <b>3/11/59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-14-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 13 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon to pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 1SM 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2946

## CERTIFICATE OF DEATH

102933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <i>3/20/4</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3016 Elizabeth Avenue</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Meyer</b>		First	Middle	Last	4. DATE OF DEATH <b>3 2 19 59</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-98</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.P.A. Cashier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Joseph Astrin</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Sarah Gitle</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Springfield State Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral and peripheral arteriosclerosis</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, without qualifying phrase.</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>January 2, 1959</b> , to <b>March 2, 1959</b> , that I last saw the deceased alive on <b>March 2, 1959</b> , and that death occurred at <b>9:25 A.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>									
DATE SIGNED  ACTUAL SIGNATURE <b>Walter Knopp, M.D.</b>									
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 4, 59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>And Shalom</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Jernson</b>		ADDRESS <b>12m. 1124 W. North Ave</b>		24a. REC'D BY REGISTRAR <b>DAT MAR 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - STATEMENT OF  
CERTIFICATE OF STATE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2947

## CERTIFICATE OF DEATH

112934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>R. Jancetown</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Route 97</i>		d. STREET ADDRESS <i>1628 Eutaw Place</i>	
3. NAME OF DECEASED (Type or print) <i>EARL</i>		First <i>EDGAR</i>	Middle <i>Ausherman</i>
4. DATE OF DEATH <i>Dec. 12, 1959</i>		Lost <i>Jr</i>	Month <i>3</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 12, 1919</i>		9. AGE (in years last birthday) <i>40 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10b. KIND OF BUSINESS OR INDUSTRY <i>Shipyard</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. IF UNDER 24 HRS. Days <i>0</i>
13. FATHER'S NAME <i>Earl E. Ausherman, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Goldie Clem</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>World War II</i>	17. INFORMANT Mrs. Anna M. Ausherman - 1628 Eutaw Place
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto. Scale - Crushing injury to chest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>825X</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>3 14 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>R 99</i>
20f. (City or town) <i>Jancetown</i>		(County) <i>Baltimore</i>	
		(State) <i>Md.</i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Westminster</i>	
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED <i>Mar 16 '59</i>	
PHYSICIAN'S NAME (Type) <i>JAMES T. MARSH</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/18/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cem.</i>
22d. LOCATION (City, town, or county) <i>Frederick, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James J. Wickner &amp; Sons</i>		24a. ADDRESS <i>Baltimore 17, Md.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
		24a. REC'D BY REGISTRAR <i>Mar 16 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2948

## CERTIFICATE OF DEATH

Reg. Dist. No.

02935

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 y l m l d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2, Md.</b>		d. STREET ADDRESS <b>1032 Greenmount Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b>Henry</b>	Last <b>Bach</b>	4. DATE OF DEATH <b>3 8 1959</b>	Month <b>3</b>	Day <b>8</b>	Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-</b>	9. AGE (In years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brush maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Peter Bach</b>				14. MOTHER'S MAIDEN NAME <b>Mary Metzger</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>S.S. Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE CAUSE OF DEATH, OR GIVING INFORMATION GIVEN IN PART I (a) <b>C.E.S. assoc. with severe psychosis with psychotic reaction Fracture of neck, right femur</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. slipped and fell striking his right hip M.E. released the body</b>							
20c. TIME OF INJURY Month Hour a. m. p. m. <b>2 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>25</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hosp. ward</b>		20f. (City or town) (County) (State) <b>Sykesville, Carroll Md.</b>			
21. I certify that I attended the deceased from <b>2-7-</b> , 1958, to <b>3-7-</b> , 1959, that I last saw the deceased alive on <b>3-7-</b> , 1959, and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>3-8-59</b>									
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/11/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.A. Heemann</b>				ADDRESS <b>6067 Harford R.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '59</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF HAWAII - DEPARTMENT OF

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2949

## CERTIFICATE OF DEATH

Reg. Dist. No.

02936

1. PLACE OF DEATH o. COUNTY Carroll c. Sykesville		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Baltimore city 311 COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB 2 years 3 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 44, Md 3801-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp.		d. STREET ADDRESS 2914 Alvarado square		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Julia	Middle Sophie	Last Bitzel	4. DATE OF DEATH 3	Month Day Year 27 1959	
5. SEX fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-76	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Bitzel			14. MOTHER'S MAIDEN NAME Barbara Stein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Bronchopneumonia DUE TO Arteriosclerotic heart disease (c)						INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psych.reaction						PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 12 - 13, 1956, to 3 - 27, 1959, that I last saw the deceased alive on 3 - 27, 1959, and that death occurred at 3:15 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE	Rita S. Glaun RITA S. GLAUN	M.D.	Springf. State Hosp.			DATE SIGNED 3-27-59
22a. BURIAL/CREMATION/ REMOVAL (Specify)	22b. DATE THEREOF 3/30/59	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood		22d. LOCATION (City, town, or county) Balto Md	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS Leonard J. Luck 5301 Harford	24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Tracy		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left attached, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2950 CERTIFICATE OF DEATH

112937

Reg. Dist. No.

**HOSPITAL OR ATTENDANT:** Physician: The law requires that the death certificate be executed within 24 hours after death. Page II may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HIGH ST</b>		d. STREET ADDRESS <b>HIGH ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARGARET B. BIXLER</b>		First	Middle	Last	4. DATE OF DEATH <b>MARCH 12 1959</b>	Month	Day	Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1880</b>	9. AGE (in years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS Days <b>12</b>	12. IF UNDER 24 HRS Hours <b>12</b>	13. MIN. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>DAVID ENGLER</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA CHASSE</b>		Address <b>MD MRS. CULLEN BARNETT, NEW WINDSOR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>MRS. CULLEN BARNETT, NEW WINDSOR</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>		DUE TO <b>K22.1</b>		b. <b>arteriosclerotic Cardio-Vascular</b>		c. <b>disease - years.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>(b)</b>		DUE TO <b>p.m.</b>		(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>New Windsor</b>		(County) <b>MD</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>3/8/59</b> , 19, to <b>3/12/59</b> , 19, that I last saw the deceased alive on <b>3/12/59</b> , 19, and that death occurred at <b>7:28</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>New Windsor, MD</b>							DATE SIGNED <b>3/12/59</b>
ACTUAL SIGNATURE <b>M. E. Robertson</b>		NAME (Type) <b>M. E. ROBERTSON</b>							NAME (Type) <b>NEW WINDSOR MD</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/15/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>PIPE CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL COUNTY MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. D. Hartman Sons New Windsor MD</b>		ADDRESS <b>112 Main St. New Windsor MD</b>		24a. REC'D BY REGISTRAR <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll &amp; Hartman</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102938

2951

## CERTIFICATE OF DEATH

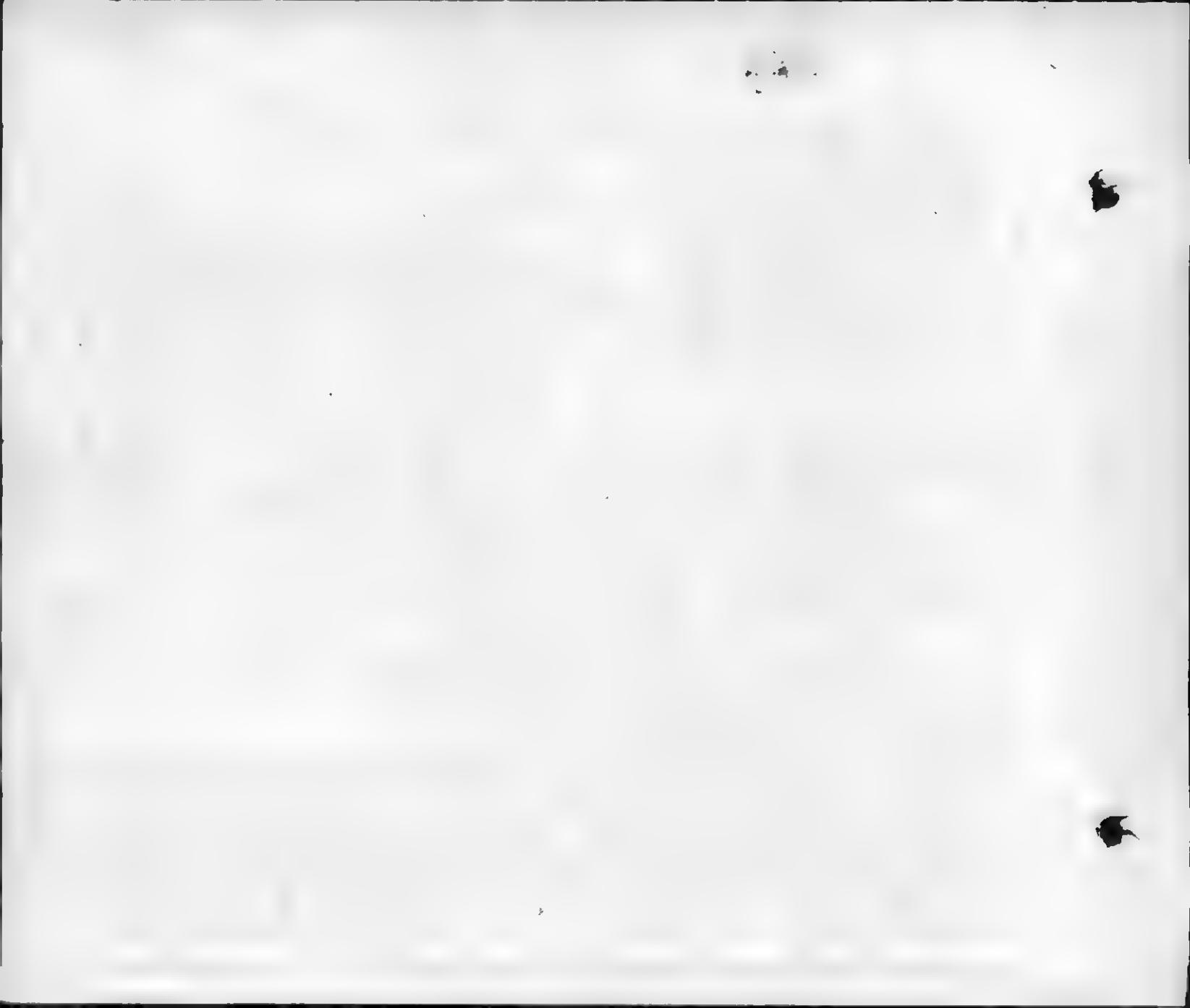
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN lb <b>YEARS</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RAILROAD STREET</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>RAILROAD STREET</b>				
3. NAME OF DECEASED (Type or print) <b>JOHN IRVIN BONE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1959</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 1 - 1893</b>			
9. AGE (In years last birthday) <b>65 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SPORT CENTER</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>THOMAS BONE</b>		14. MOTHER'S MAIDEN NAME <b>JENNY FOGLE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-6004</b>	17. INFORMANT <b>MARY M BONE UNION BRIDGE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure - ?etiology</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 wks.</b>				
545X Conditions, if any, which gave rise to immediate cause (a) <b>b.</b>		DUE TO				
DUE TO						
DUE TO						
Cirrhosis of the liver, Arteriosclerotic cardiac disease		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20f. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) <b>FREDERICK CO</b>	(County) <b>MD</b>	(State)
21. I certify that I attended the deceased from <b>Feb 28</b> , 1959, to <b>March 30</b> , 1959, that I last saw the deceased alive on <b>March 30</b> , 1959, and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>Joseph H. Caron</i>		PHYSICIAN'S NAME (Type) <b>M.D. 118 S Main, Union Bridge, Md. March 30 '59</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>APR 2-1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>HAUGHS</b>	22d. LOCATION (City, town, or county) <b>FREDERICK CO MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Hartzelin &amp; Sons, Union Bridge</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>APR 1 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. **Log #**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



1  
FOR STATE  
HEALTH DEPT.  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN lb <b>lyrs. 10 mos. 26 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City - Zone 13</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>	d. STREET ADDRESS <b>1821 N. Montford Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Albert Hilliker</b>	First <b>Albert</b>	Middle <b>Hilliker</b>	Last <b>BOWLER</b>	4. DATE OF DEATH <b>March 29, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 5, 1894</b>	9. AGE (In years last birthday) <b>64 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Sheet Metal Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY - -	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren Bowler</b>	14. MOTHER'S MAIDEN NAME <b>Annie -</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> 1st W.W.	16. SOCIAL SECURITY NO - - - - -	17. INFORMANT <b>Springfield Hospital Records</b>

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>522X</b> DUE TO Asphyxia due to occlusion of larynx by solid food.	INTERVAL BETWEEN ONSET AND DEATH Minutes
Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause lost. (b) DUE TO Pulmonary edema	Minutes

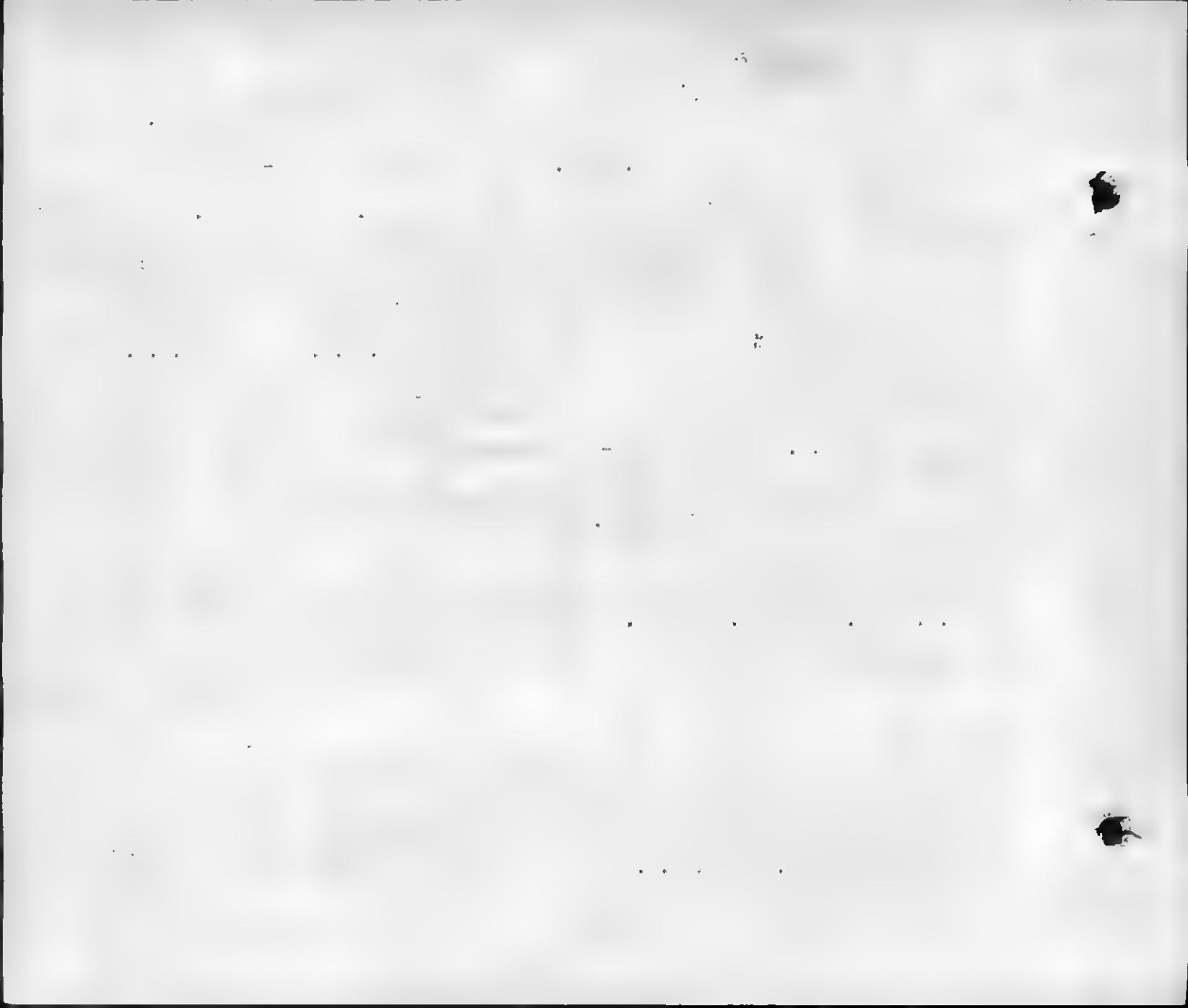
MEDICAL CERTIFICATION C.B.S. assoc. with conv. disorder.	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
---

ACTUAL SIGNATURE: James T. Marsh M.D. DATE SIGNED: 3/30/59

EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF <b>4-3-59</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur &amp; Thomas</b>	24a. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thomas</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2953

## CERTIFICATE OF DEATH

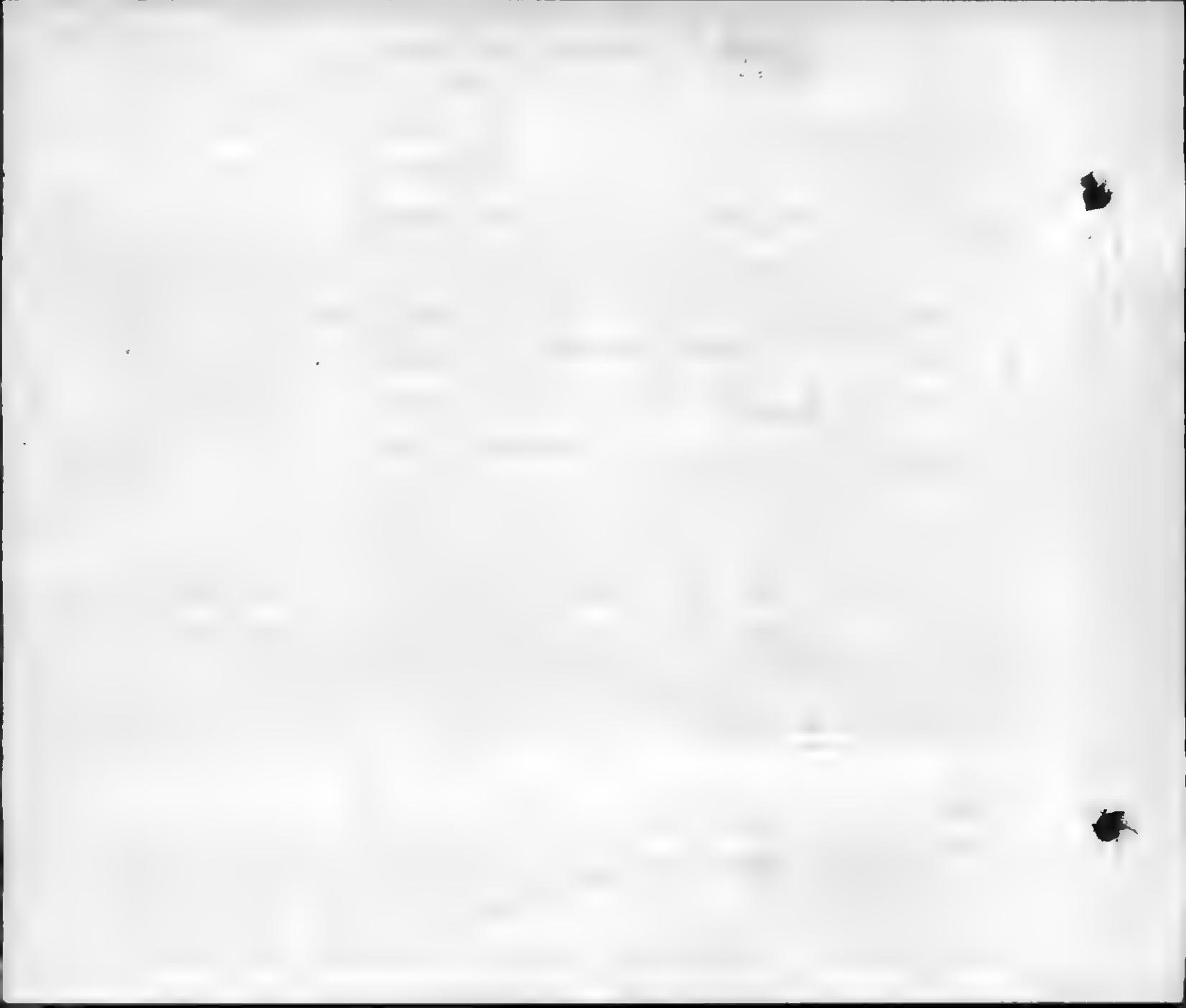
02940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roxbury, Taneytown</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portsmouth</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Roxbury 97</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>JOHN</u>	Middle <u>Russel</u>	Last <u>BRENNAN</u>
4. DATE OF DEATH	3	Month	Day 14 Year 1959
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-17</u>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Brennan</u>		14. MOTHER'S MAIDEN NAME <u>Lessie Dowdy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>Yes WW2</u>		16. SOCIAL SECURITY NO. <u>Address</u>	
17. INFORMANT <u>Ericson &amp; Ericson, 500 State Street, Brooklyn, N.Y.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cruising injury chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20c. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20d. TIME OF INJURY Month, Day, Year <u>Hour 6 m. 3 14 1959</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roxbury 97</u>	
20f. (City or town) <u>Taneytown, Carroll, Md.</u>		(County) <u>Carroll</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>James T. Marsh - Deputy, Md. Coroner</u>		ADDRESS (Street, city or town, state) <u>Lebanon, Md.</u> DATE SIGNED	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>National Cemetery</u>		22d. LOCATION (City, town, or county) <u>Long Island</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Fuss</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	
C. OFUSS & SON		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2954

## CERTIFICATE OF DEATH

Reg. Dist. No.

02941

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Uniontown</i>	c. LENGTH OF STAY IN lb <i>X</i>	b. COUNTY <i>Carroll</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Uniontown</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Wilson</i>	Middle <i>L.</i>	Last <i>Brown</i>
4. DATE OF DEATH	Month <i>3</i>	Day <i>- 19 -</i>	Year <i>1959</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 19, 1894</i>
9. AGE (In years last birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tilling Station</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Alpheus W. Brown</i>	14. MOTHER'S MAIDEN NAME <i>Nellie Logsdon</i>	Address <i>Mrs. Marguerite Brown, Rt 5 Westminster.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>273-05-7850</i>	17. INFORMANT <i>Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>Bronchogenic Carcinoma</i>
			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo -</i>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>December 1953</i> to <i>Mar 19 1959</i> , that I last saw the deceased alive on <i>Mar 19 1959</i> , and that death occurred at <i>105 E Main St</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James T Marsh</i>	M.D.	ADDRESS (Street, city or town, state) <i>105 E Main St</i>	DATE SIGNED <i>3-19-59</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/23/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Gardens of Faith</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road.</i>	ADDRESS <i>Leonard J. Ruck 5305 Harford Road.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

102942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write route and give nearest town) Manchester	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write route and give nearest town) Manchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 S. Main Street		d. STREET ADDRESS 110 S. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Burgess	First Middle Last	4. DATE OF DEATH Month Day Year	March 23 1959
5. SEX F	6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	10c. BIRTHPLACE (State or foreign country) Carroll Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Berkheimer	14. MOTHER'S MAIDEN NAME Philadelphia Nagle	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Marie G. Greifenstein, P. O. Box 100	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease 2 yrs (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Manchester	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from <u>Aug 47</u> , 19____, to <u>March 23, 1959</u> , that I last saw the deceased alive on <u>March 23, 1959</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Ford</u>	ADDRESS (Street, city or town, state) <u>Manchester, Md</u> DATE SIGNED <u>3/25/59</u>		
PHYSICIAN'S NAME (Type) <u>W H Ford MD</u>	<u>MANCHESTER, MD</u>		
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>	22d. LOCATION (City, town, or county) <u>Manchester, Carroll Co.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Becker</u>	ADDRESS <u>110 S. Main Street, Manchester, Pa.</u>	24a. REC'D BY REGISTRAR <u>Arthur S. Khan</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Khan</u>
VS 15 (4) 1SM 9/55		DATE MAR 26 '59	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

112944

Reg. Dist. No.

2956

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. LENGTH OF STAY IN lb <b>2 yrs 3 mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSP</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
f. STREET ADDRESS <b>262 E MAIN ST</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NORA</b>	First	Middle	Last
4. DATE OF DEATH <b>3</b>	Month	Day	Year <b>12 1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-74</b>
9. AGE (In years last birthday) <b>84</b>	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>CAUSA</b>
13. FATHER'S NAME <b>PETER BUCHMAN</b>	14. MOTHER'S MAIDEN NAME <b>HARY RUTH</b>	Address <b>SPRINGFIELD Hospital. SYKESVILLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>SPRINGFIELD Hospital. SYKESVILLE</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIO-SCLEROSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <b>CARDIO-VASCULAR Disease</b> DUE TO (b) <b>Broncho pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>One week</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/15</b> , 1959, to <b>3/12</b> , 1959, that I last saw the deceased alive on <b>12 MARCH 1959</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Yves H. Boenner</b> PHYSICIAN'S NAME (Type) <b>YVES H. BOENNER</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Westminster Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Westminster, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr., Westminster, Md.</b>	ADDRESS	24a. REG'D. BY REGISTRAR DATE <b>MAR 16 59</b>	24b. REGISTRAR'S SIGNATURE <b>Carine S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be affixed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GENEVALES ARTERIO-ARTERIOSIS

CISDIO-AZURANAS DRUGS

Baclofen. Baclophen

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

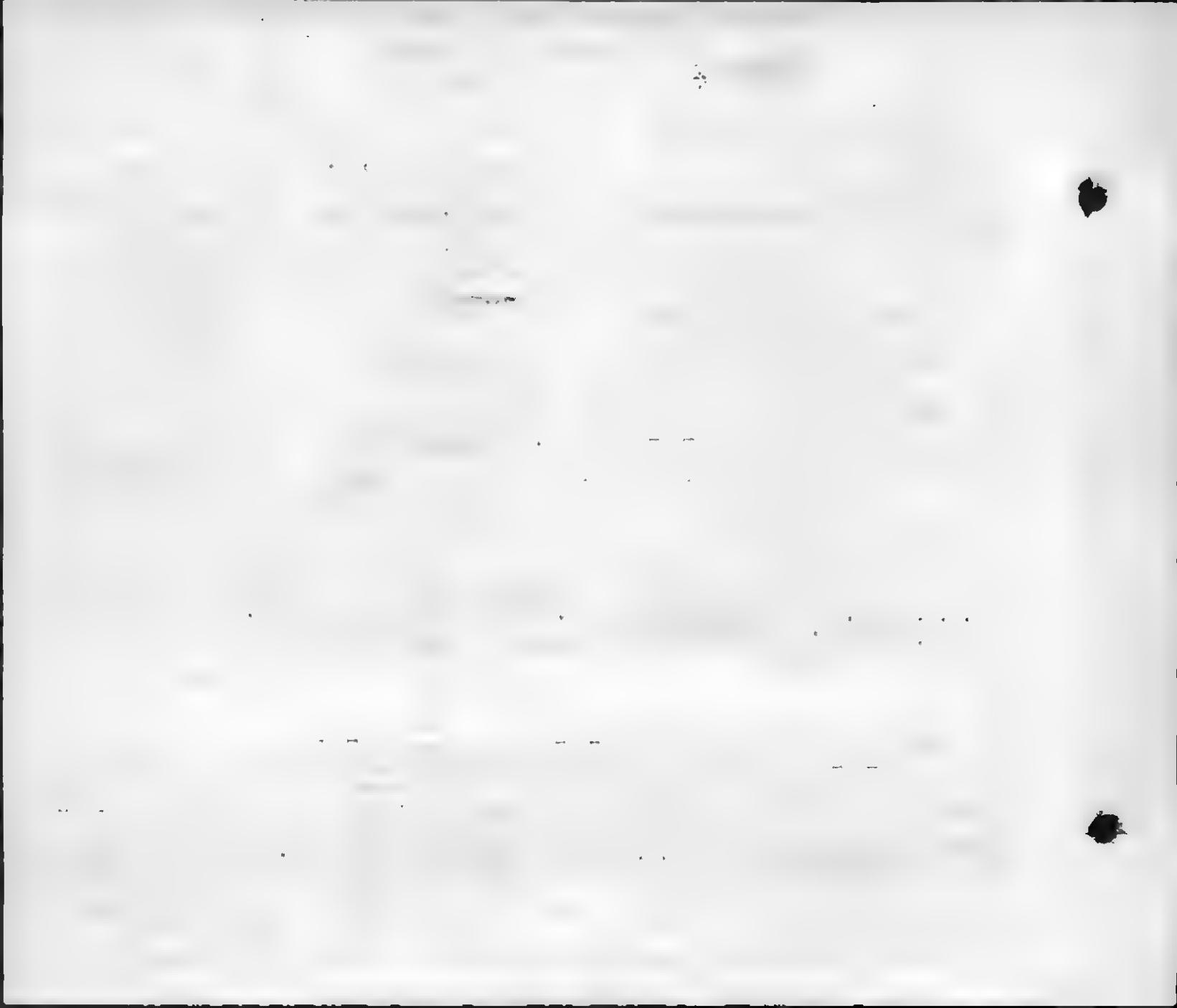
182945

## CERTIFICATE OF DEATH

Reg. Dist. No.

2957

1 PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c LENGTH OF STAY IN 1b <b>1 y 2 m</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 31, Md.</b>		d STREET ADDRESS <b>118 S. Ann Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Antonio ANTONY</b>		First	Middle	Last	4. DATE OF DEATH <b>Cascio</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-11-1874</b>	9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>unkn</b>		
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>CASCIO</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>218-10-1127</b>		
17. INFORMANT <b>S.S. Hospital Records</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>		Address		
				DUE TO <b>422.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>		
				Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
				PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with circulatory disturb. with cerebral arterioscler. with reaction. Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
20g ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20h DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____ A.M., from the causes and on the date stated above.		1-28-1958		3-27-1959		ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		M.D.		Springfield State Hospital		DATE SIGNED <b>3-28-59</b>		
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		Sykesville, Maryland.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/31/59</b>		22c NAME OF CEMETERY OR CREMATORIUM <b>MORELAND PARK</b>		22d LOCATION (City, town, or county) <b>THYLOR AVE</b> (State) <b>MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Doppel Bros</i>		ADDRESS <b>1800 E. LOMBARD ST</b>		24a REC'D BY REGISTRAR <b>MDP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <i>John K. ...</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102946

2940

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)							
Carroll Co.		a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Md.</i>							
c. LENGTH OF STAY IN 1b <i>75 yrs.</i>		d. STREET ADDRESS <i>216 E. Main St.</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>216 E. Main St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle						
CLARA LIZZIE CASSELL			Last						
4. DATE OF DEATH		Month	Day						
		MARCH	20						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY?
Female White				May 4, 1872 86	86				Mc Kenney Mill, Carroll, Md. U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Mc Kenney Mill, Carroll, Md. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Henry B. Albaugh		Anna L. Brodecks							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(All yes, give war or dates of service)		—		Mrs. Wm. H. Vandeford, Westminster, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  40214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Chronic Valvular Heart Disease Senility & Arteriosclerosis 5 yrs				10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from <i>Oct</i> , 1958, to <i>March 20</i> , 1959, that I last saw the deceased alive on <i>March 19</i> , 1959, and that death occurred at <i>410 Wm. H. Vandeford</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)		<i>W. GLEN K SPEICHER</i>				DATE SIGNED <i>3/20/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
<i>Burial</i>		<i>March 23, 1959</i>		<i>Westminster Cemetery, Westminster, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>J. S. Myers, Jr., Westminster, Md.</i>				DATE MAR 23 '59		<i>Arthur S. Krause</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102947

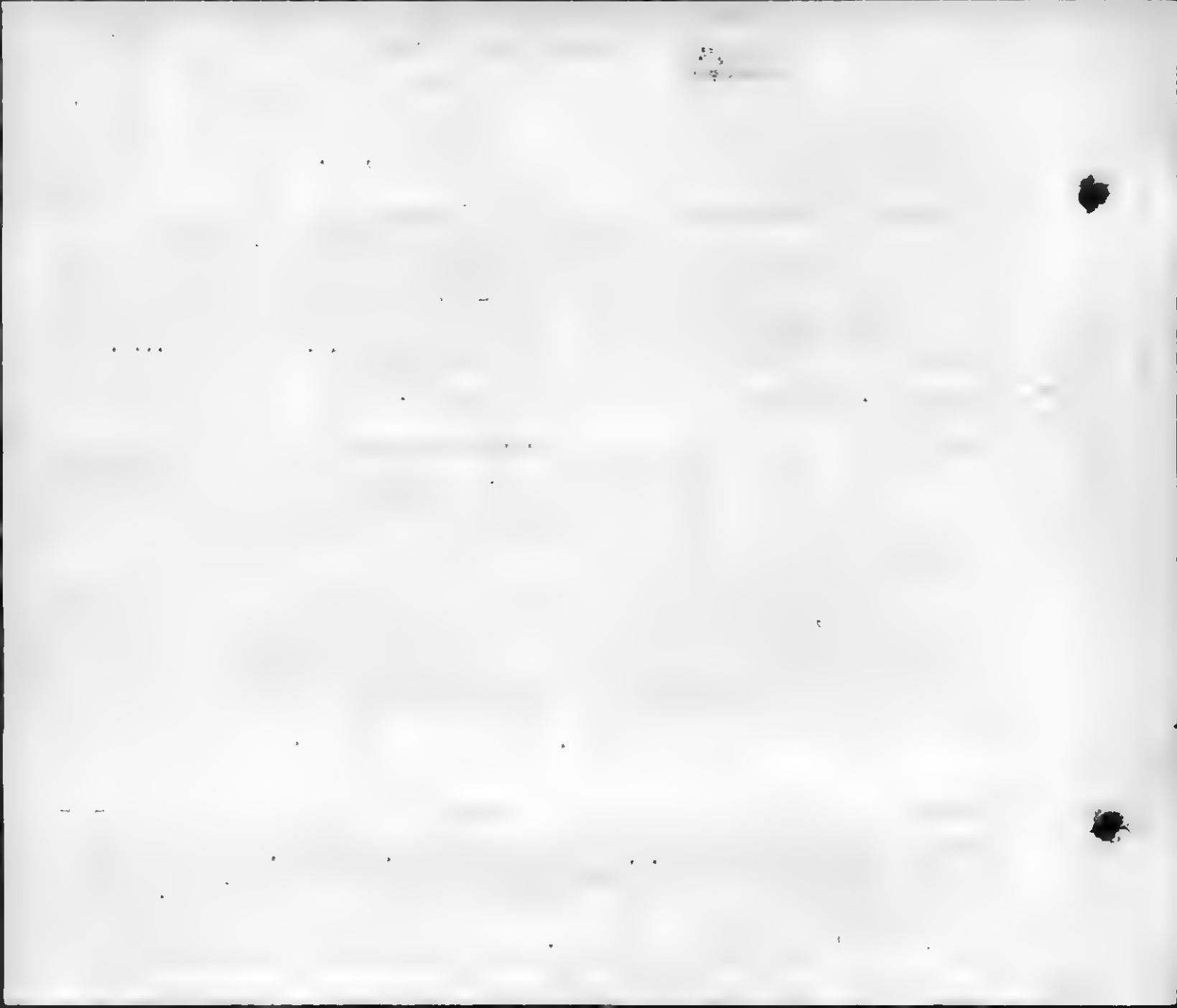
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>13 y 4 m 7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5503 -42 nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Helen</b>	Middle <b></b>	Last <b>Clagett</b>	4. DATE OF DEATH <b>3</b>	Month <b>7</b>	Day <b>19</b>	Year <b>59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4 - 2 - 05</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles W. Clagett</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Beale</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>S.S. Hospital Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastases to lungs</b> DUE TO <b>170 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenia, hebephrenic type</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Oct. 20, 1954, to March 7, 1959, that I last saw the deceased alive on 3 - 7 - 1959, and that death occurred at 7:05 P.M. from the causes and on the date stated above.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>3-8-59</b>				
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Episcopal</b>		22d. LOCATION (City, town, or county) <b>Upper Marlboro Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knapp</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death  
**may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02948

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Carroll</b>		2959		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Sykesville</b>		c. LENGTH OF STAY IN TB <b>30 yrs. 6mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillsdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Ellen</b>	Last <b>Coyne</b>	4. DATE OF DEATH <b>March</b>	Month <b>30,</b>	Day <b>19</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-88</b>	9. AGE (in years last birthday) <b>70</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jerome Coyne</b>		14. MOTHER'S MAIDEN NAME <b>Ella Doyle</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For info or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Hospital Records</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>General arteriosclerosis</b> Years (c) <b>Chronic brain syndrome associated with convulsive disorder</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with convulsive disorder</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-7-</b> , 19 <b>28</b> , to <b>3-30-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-30</b> , 19 <b>59</b> , and that death occurred at <b>9:10 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>							
ACTUAL SIGNATURE <b>Ilse Kamm, M. D.</b>							
DATE SIGNED <b>3/30/59</b>							
PHYSICIAN'S NAME (Type)		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3207 W North Ave.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kamm</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kamm</b>	
DATE <b>APR 1 '59</b>							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

102949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1312 W. 40th Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Herbert</b>	Middle <b>William</b>	Last <b>Crist</b>	4. DATE OF DEATH <b>March 12, 1959</b>	Month <b>March</b>	Day <b>12</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/84</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner - mill hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. COUNTRY (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>161-12-7928</b>	
				17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> DUE TO <b>420.0</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized arteriosclerosis.</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/19</b> , 1959, to <b>3/12</b> , 1959, that I last saw the deceased alive on <b>3/11/59</b> , 1959, and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE <b>Agustin del Campo</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>							
22b. DATE THEREOF <b>March 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Calvary</b>		22d. LOCATION (City, town, or county) <b>Altoona, Pennsylvania</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>							
ADDRESS <b>3631 Falls Road</b>		24a. REC'D BY REGISTRAR <b>MAR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Elmer S. Krause</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02950

2961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Rosemont</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood, Md.</i>		c. LENGTH OF STAY IN 1b <i>18 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood, Md.</i>		d. STREET ADDRESS <i>1000 1/2 S. Highland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i></i>	Last <i>DAVIS</i>	4. DATE OF DEATH <i>March 1959</i>	Month <i>March</i>	Day <i>1</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July - 1869</i>	9. AGE (In years lost birthday) <i>90 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ag. Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John D. Davis</i>		14. MOTHER'S MAIDEN NAME <i>McGilligan</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>McGilligan</i>		Address <i>McGilligan Avenue - Highland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular heart Disease, arteriosclerosis</i> DUE TO <i>420.0</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1955</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>generalized, hypertension, chronic brain</i>						TO <i>to</i>	
(c) <i>Syndrome</i>						1 March 59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> , to <i>1 March</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1 March</i> , 19 <i>59</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) <i>Ashburn, Md.</i>					
PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>		DATE SIGNED <i>1 March 59</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-3-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Adult Rock</i>		22d. LOCATION (City, town, or county) (State) <i>Brentwood, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS <i>Hopewell, Md.</i>		24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102951

2962

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos.4days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore XX				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Formerly of 4010 8409 Belair Road Roland Ave.				
3. NAME OF DECEASED (Type or print)		First Lucy	Middle B. deMOSS	Last DeMoss	4. DATE OF DEATH March	Month 26,	Day Year 1959	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 68 yrs.	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper - Retired -Md. Casualty Co.				10b. KIND OF BUSINESS OR INDUSTRY Maryland				
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Harry G. DeMoss deMoss				14. MOTHER'S MAIDEN NAME Jennie Winkler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-10-3334		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Years  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis Years  DUE TO (c)								
C.PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from December 22, 1958, to March 26, 1959, that I last saw the deceased alive on March 25, 1959, and that death occurred at 3:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)								DATE SIGNED 3/26/59
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D. Springfield State Hospital						
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/59		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Woodlawn, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Nickens &amp; Sons</i> Balto - 17 Md.				ADDRESS		24a. REC'D BY REGISTRAR MAR 30 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2963

## CERTIFICATE OF DEATH

02952

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>		c. LENGTH OF STAY IN lb <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>X NEW WINDSOR</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOUIS HENRY DIELMAN</b>		First	Middle
4. DATE OF DEATH <b>MARCH 8 1959</b>		Last	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 16 - 1864</b>
9. AGE (in years lost birthday) <b>95 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>KEEPER OF BOOKS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CARTERIAN</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>LOUIS DIELMAN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BARKDOLL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ROBERT CAIRNS</b>		Address <b>NEW WINDSOR MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic C.V.D.		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/1/48</b> , 19, to <b>3/8/59</b> , 19, that I last saw the deceased alive on <b>3/7/59</b> , 19, and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b>		DATE SIGNED <b>3/8/59</b>	
22a. MEDICAL CERTIFICATION SIGNATURE <b>M.E. Robertson</b>		22b. PHYSICIAN'S NAME (Type) <b>M. E. ROBERTSON</b>	
22c. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22d. DATE THEREOF <b>3/11/59</b>	22e. LOCATION (City, town, or county) <b>CARROLL CO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kline</b>		24a. ADDRESS <b>11 Party Lane, New Windsor, Md.</b>	
24b. REC'D BY REGISTRAR DATE <b>MAR 12 '59</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G241, 4/1/59 fcy

112953

2964

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Carroll	
c. LENGTH OF STAY IN 1b 72 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
J. L. C. Frank			Frank
4. DATE OF DEATH	Month	Day	Year
Mar.	31	1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-11-1886
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
72 yrs			
10a. USUAL OCCUPATION (Give kind of work done) during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Gandy		14. MOTHER'S MAIDEN NAME Moore Ritter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Frank Gandy - Blood relative		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO (b) alive at 11:30 P.M., died on 3/27/59 at 11:45 P.M. DUE TO (c) physical pain with			
INTERVAL BETWEEN ONSET AND DEATH 11:30 P.M. to 11:45 P.M. 15 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10:30 A.M. to 3:15 P.M. on 3/27/59, that I last saw the deceased alive on 3/27/59, and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Sykesville, Md.	
PHYSICIAN'S NAME (Type) Howard E. Hall		DATE SIGNED 3/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-59	
22c. NAME OF CEMETERY OR CREMATOR Y Springfield		22d. LOCATION (City, town, or county) Frederick	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thack		ADDRESS	
24a. REC'D BY REGISTRAR APR 6 '59		24b. REGISTRAR'S SIGNATURE	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2965

### CERTIFICATE OF DEATH

02954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		c. LENGTH OF STAY IN lb <b>23 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Ernest</b>	Middle <b>Woodruff</b>	Lost	4. DATE OF DEATH <b>March 2,</b>	Month	Day	Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1880</b>	9. AGE (In years lost birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Manufacturing</b>		11. BIRTHPLACE (State or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Japeth Dunbar</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>029-07-8415</b>		17. INFORMANT <b>Mrs. Emily Dunbar, Taneytown, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>DUE TO</b> <b>Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>few Minutes</b>					
(b) DUE TO <b>Arteriosclerotic Heart Disease</b>						<b>2 years</b>			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Taneytown, Md.</b>		20f. (City or town) <b>Taneytown, Md.</b>		(County) <b>Taneytown, Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Oct. 26, 1958</b> , to <b>Mar. 21, 1959</b> , that I last saw the deceased alive on <b>May 2, 1959</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above						ADDRESS (Street, city or town, state) <b>Taneytown, Md.</b>		DATE SIGNED <b>3/4/59</b>	
ACTUAL SIGNATURE <b>R. S. McVaugh</b>									
PHYSICIAN'S NAME (Type) <b>R. S. McVaugh</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) <b>Taneytown, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merle C. Fuss</b>		ADDRESS <b>C.O. Fuss &amp; Son</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knott</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112955

2966

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Carroll Co.

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Westminster

c. LENGTH OF STAY IN 1b

1 yr.

## d. NAME OF HOSPITAL (If not in hosp tol, give street address) OR INSTITUTION

Medic View Convalescent Home

e. IS RESIDENCE ON A FARM?  
YES  NO 3. NAME OF DECEASED  
(Type or print)

First CORA Middle MAE Last ESSICK

## 4. DATE OF DEATH

Month March Day 29 Year 1959

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

Sep 27 1875

9. AGE (In years  
less birthday)  
yrs.

84

## 10. IF UNDER 1 YEAR IF UNDER 24 yrs.

Months Days Hours Min

## 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

## 10b. KIND OF BUSINESS OR INDUSTRY

—

## 11. BIRTHPLACE (State or foreign country)

Silver Run Carroll Md. U.S.A.

## 12. CITIZEN OF WHAT COUNTRY?

Silver Run Carroll Md. U.S.A.

## 13. FATHER'S NAME

Henry Kortz

## 14. MOTHER'S MAIDEN NAME

Mary Flock

## Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

Yes, give war or dates of service

## 16. SOCIAL SECURITY NO.

—

## 17. INFORMANT

Oscar L. Schild, Westminister Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

442 X DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause lost.

## (b) DUE TO

Hypertension Arteris Sclerosis

## (c) DUE TO

+ myocardial degeneration

INTERVAL BETWEEN  
ONSET AND DEATH

Several

YES  NO 

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

## 20c. TIME OF INJURY Month, Day, Year

Hour o. m. 19

p. m.

## 20d. INJURY OCCURRED

While Not while

at work at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

## 21. I certify that I attended the deceased from Aug 20, 1957 to March 29, 1957, that I last saw the deceased

alive on March 29, 1957,

and that death occurred at 4:30 PM, from the causes and on the date stated above.

## ADDRESS (Street, city or town, state)

## DATE SIGNED

Actual Signature

Physician's Name (Type)

W. Lewis Specchio, Westminster Md. 3/29/57

## 22a. BURIAL CREMATION, DATE THEREOF

REMOVAL (Specify)

Burial April 5, 1959

Cremation Cemetery

Westminster, Md.

## 22b. LOCATION (City, town, or county)

(State)

## 22c. NAME OF CEMETERY OR CREMATORI

ADDRESS

## 24a. REC'D BY REGISTRAR

## 24b. REGISTRAR'S SIGNATURE

DATE APR 1 '59

Arthur &amp; Anna

E. Myers Jr. Westminster Md.

VS A15 (4)

15M 9/55



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2967

### CERTIFICATE OF DEATH

02956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 46yr 3mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1812 West Fayette Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude		4. DATE OF DEATH March 21 1959	
5. SEX female		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 25, 1880	
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Birth U.S.A.	
13. FATHER'S NAME Lewis C. Frederick		14. MOTHER'S MAIDEN NAME Henrietta Naas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO none	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH month years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental deficiency, Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15, 1958, to March 21, 1959, that I last saw the deceased alive on March 21, 1959, and that death occurred at 1:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Konstantin Weber M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3-21-1959	
PHYSICIAN'S NAME (Type) Konstantin WEBER		Oak St., Sykesville Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cem.		22d. LOCATION (City, town, or county) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Sickner & Sons - Beltsville		24a. REC'D BY REGISTRAR MAR 23 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Cirilus S. Kie	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02957

## CERTIFICATE OF DEATH

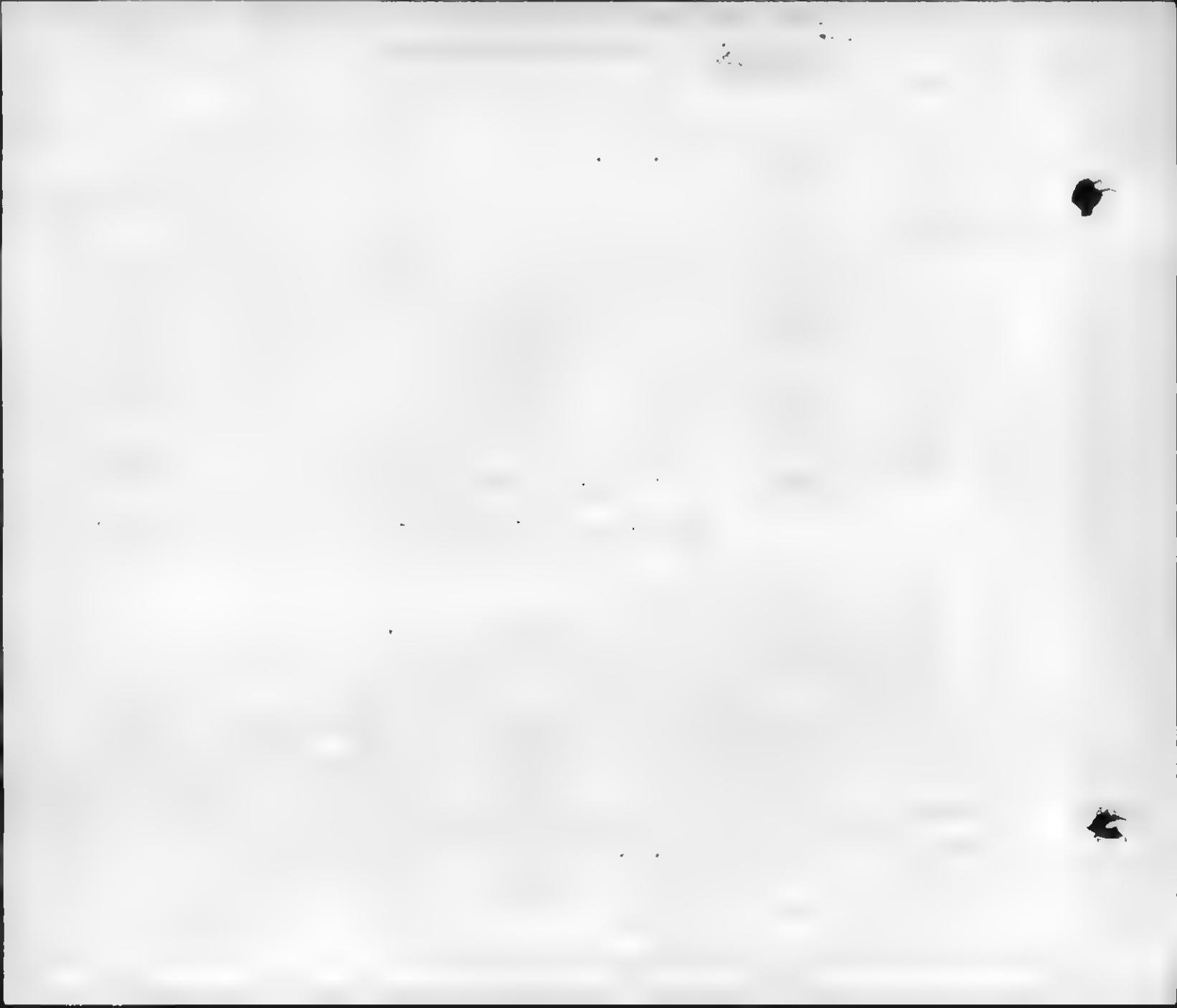
Reg. Dist. No.

2968

1. PLACE OF DEATH o COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 3yr. 7mos. 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Curley	Last (Phipps) FRIZZELL
4. DATE OF DEATH March 16	Month March	Day 16	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-65
9. AGE (In years lost birthday) 93 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Phipps		14. MOTHER'S MAIDEN NAME Lina TAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO Unk.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis DUE TO		Years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21, 1955, to 3-16, 1959, that I last saw the deceased alive on 3-15, 1959, and that death occurred at 8:30A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmund Lusthaus, M.D. Springfield State Hospital Sykesville, Maryland DATE SIGNED 3-16-59			
ACTUAL NATURE		PHYSICIAN'S NAME (Type)	
Edmund Lusthaus, M. D.		22d. LOCATION (City, town, or county) Edensburg, Carroll, Md. (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 3-18-59	
22g. NAME OF CEMETERY OR CREMATORIUM McCombs Cr.		22h. REGISTRAR'S SIGNATURE John S. Hough	
23. FUNERAL DIRECTOR'S SIGNATURE Sister A. Height (Signature, typed)		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
ADDRESS Kirkville, Md.		24b. REGISTRAR'S SIGNATURE John S. Hough	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02958	
2969 CERTIFICATE OF DEATH					Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 3mos.23days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS None					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Kline Gardner						4. DATE OF DEATH March 2, 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1871		9. AGE (In years less birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor			10b. KIND OF BUSINESS OR INDUSTRY Railroad			11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward F. Gardner					14. MOTHER'S MAIDEN NAME Henrietta Kurtz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH Years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis										Years	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour e. m. 19 p. m.		20d. INJURY OCCURRED While not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from December 9, 1958, to March 2, 1959, that I last saw the deceased alive on March 1, 1959, and that death occurred at 8:00A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Yves Boennec		M.D.		Springfield State Hospital		ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 3/2/59			
PHYSICIAN'S NAME (Type) Yves Boennec, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Springfield		22b. DATE THEREOF 3-4-59		22c. NAME OF CEMETERY OR CREMATORIUM Springfield		22d. LOCATION (City, town, or county) Sykesville		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02959

Reg. Dist. No.

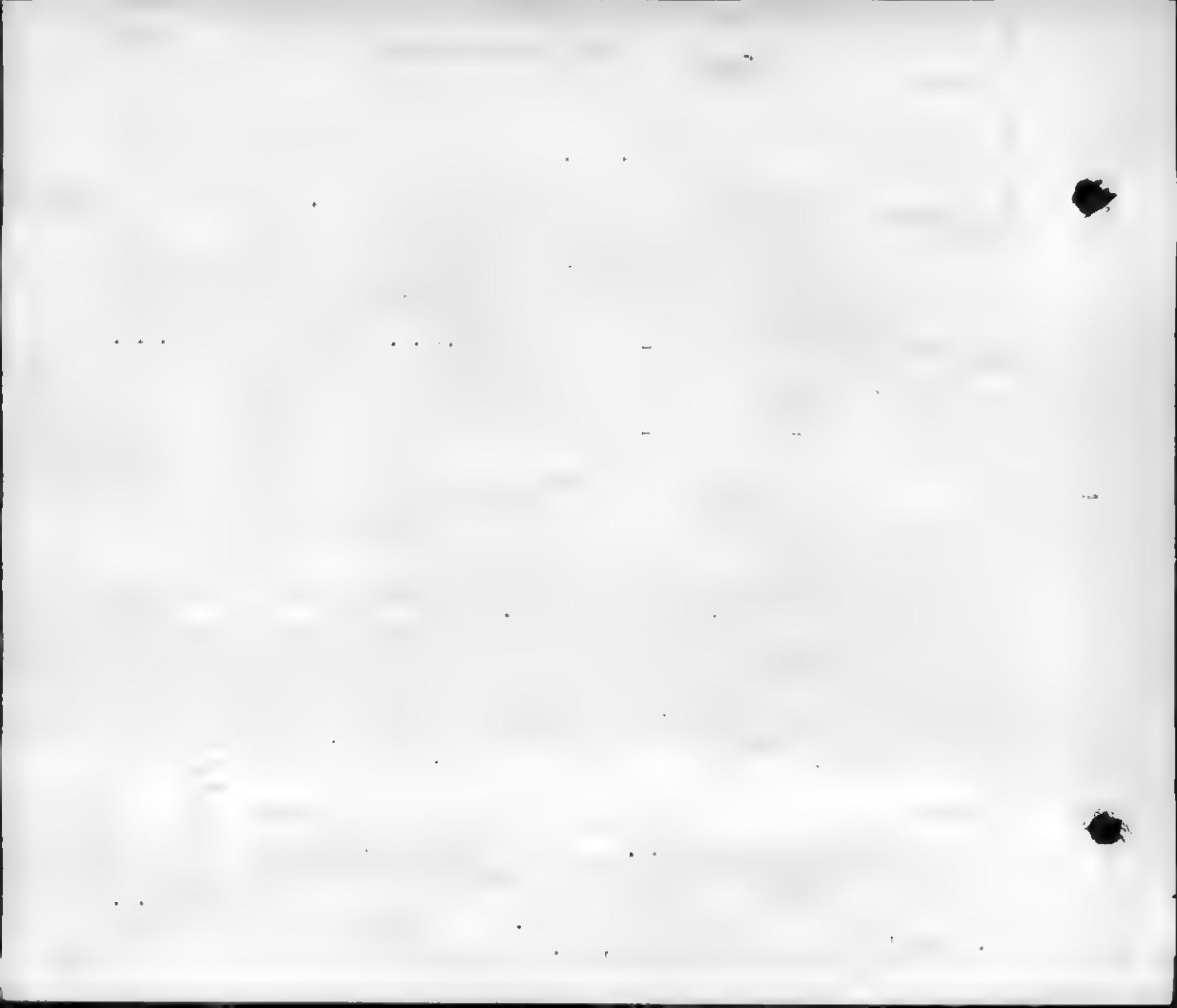
2970

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>41 yrs. 7 mos. 10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		d. STREET ADDRESS <b>4203 - 53rd Ave.</b>	
First <b>Blanch</b>	Middle <b>Gasson</b>	4. DATE OF DEATH <b>March 31, 1959</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
10c. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry J. Gasson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Gasson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Schizophrenic reaction, hebephrenic type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> , <b>March 31, 1959</b> , that I last saw the deceased alive on <b>March 30, 1959</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		ADDRESS (Street, city or town, state) M.D. <b>Springfield State Hospital</b> DATE SIGNED <b>3/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland	
22a. BURIAL CREMATION, BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek</b>		22d. LOCATION (City, town, or county) <b>Washington D.C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>APR 2 59</b>	
24b. REGISTRAR'S SIGNATURE <i>Edmund Lusthaus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02960

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH D. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2mos. 3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Snyder Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Marion	Middle Clarissa	Last Wolfe	4. DATE OF DEATH March 2, 1959	Month March	Day 2	Year 1959
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1912	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME - Wolfe Bernard		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO - - -		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the colon with metastasis to DUE TO brain, lungs, liver and adrenal.						INTERVAL BETWEEN ONSET AND DEATH Months		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, catatonic type.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bronchopneumonia.						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 29, 1958, to March 2, 1959, that I last saw the deceased alive on March 1, 1959, and that death occurred at 2:00A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Yves Boennec, M.D.						ADDRESS (Street, city or town, state) Springfield Hospital		
PHYSICIAN'S NAME (Type) Yves Boennec, M.D.						DATE SIGNED 3/2/59		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-1959		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		22d. LOCATION (City, town, or county) Fullerton Balto. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home		ADDRESS 7401 Blair Rd.		24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/54



11.000 - 11.000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c LENGTH OF STAY IN 1b 2yr.10mo.25da.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5,							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d STREET ADDRESS 2420 E. Eager Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Frank	Middle Lawrence	Last Giddy	4. DATE OF DEATH 3	Month 4	Day 14	Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-27-88	C. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood carver-painter		10b. KIND OF BUSINESS OR INDUSTRY University Hosp		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Giddy				14. MOTHER'S MAIDEN NAME Anna Pelke							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) unknown		16. SOCIAL SECURITY NO. 215-03-5212		17. INFORMANT Hospital records, Springfield State Hospital		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Bilateral Pneumonia				INTERVAL BETWEEN ONSET AND DEATH days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome, asso. with cerebral arteriosclerosis, with psychotic reaction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.	Month 00	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At <input type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 00	20f. (City or town) 00	(County)	(State)				
21. I certify that I attended the deceased from 4-9-56, 19, to 3-4-59, that I last saw the deceased alive on March 1, 1959, and that death occurred at 11:55 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Walter Knopp</i>	ADDRESS (Street, city or town, state) Springfield State Hospital M.D.						DATE SIGNED 3-4-59				
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.	Sykesville, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Matthew's Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Schumer and Son Funeral Home</i>		ADDRESS Balto. Md.		24a. REC'D BY REGISTRAR DATE MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus						

TO HOSPITAL OR ATTENDING PHYSICIAN—The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

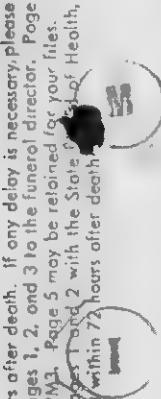
02962

Reg. Dist. No.

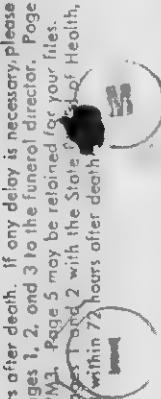
FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** Ths certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2 57



MEDICAL CERTIFICATION



1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.	
2973		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, P. O.	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville P. O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lakeside Acres, Oakland Mill Rd.		d. STREET ADDRESS Lakeside Acres, Oakland Mill Rd.	
3. NAME OF DECEASED (Type or print) <i>Ruth</i>	First Middle Last	4. DATE OF DEATH Mar 17 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1902
9. AGE (In years last birthday) 56 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry P. Barney	14. MOTHER'S MAIDEN NAME Annie Saunders		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO	17. INFORMANT Mr. Edward R. Gisburne-Sykesville P. O., Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> 151X DUE TO C-ae of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH year		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James T. Marsh</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES T MARSH	DATE SIGNED <i>3/17/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 3/20/59	22c. NAME OF CEMETERY OR CREMATORIUM Green Mount Crem.	22d. LOCATION (City, town, or county) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hiram J. Listerer &amp; Sons - Baileys</i>	ADDRESS <i>111 W. Pratt Street</i>	24a. REC'D BY REGISTRAR DATE MAR 19 '59	24b. REGISTRAR'S SIGNATURE <i>G. L. Johnson</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 on page 3 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2974 CERTIFICATE OF DEATH 02963

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. 17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>109 Stannmore Road.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Marie</b>	Middle <b>Rice</b>	Last <b>Goodwin</b>	4. DATE OF DEATH <b>March 26, 1959</b>	Month <b>March</b>	Day <b>26</b>	Year <b>19 59</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1880</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Rice</b>		14. MOTHER'S MAIDEN NAME <b>Emma Donnelly</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH Years 4 d 0. 0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Generalized arteriosclerosis</b> Years DUE TO (c) Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with conv. disorder without qualifying phrase. Broncho-</b> <b>pneumonia. Subcapital fracture, right hip.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 5, 1958</b> , to <b>March 26, 1959</b> , that I last saw the deceased alive on <b>March 26, 1959</b> , and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ives H. Boennec, M.D.</b> ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>3/26/59</b>		PHYSICIAN'S NAME (Type) <b>Ives H. Boennec, M.D.</b>		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker</b>		ADDRESS <b>Baltimore 12, Md.</b>		24a. REG'D BY REGISTRAR <b>Mar 30 1959</b>		24b. REGISTRAR'S SIGNATURE <b>J. Frame</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2975

## CERTIFICATE OF DEATH

112964

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN lb 1 mo. 27 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		former STREET ADDRESS: 1909 N. Monroe St. 5th & Paragon Dr., Balto. 12.	
3. NAME OF DECEASED (Type or print) Anna Amelia Green	First Middle Last	4. DATE OF DEATH March 5, 1959	Month Day Year
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Rd Seamstress - Laundry		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lewis Green		14. MOTHER'S MAIDEN NAME Catherine Schisler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 214-05-3377	17. INFORMANT Springfield Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
C.B. assoc. with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 8, 1959, to March 5, 1959, that I last saw the deceased alive on March 4, 1959, and that death occurred at 1:50A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital 3/5/59			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORIUM London Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR MAR 6 '59
H. J. Lickner & Sons, Balto. 17			24b. REGISTRAR'S SIGNATURE C. L. & Traub



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2976

## CERTIFICATE OF DEATH

Reg. Dist. No.

02965

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>	c. LENGTH OF STAY IN 1b <b>790 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>820 W. Franklin Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Fred</b>	Middle <b></b>	Last <b>Green</b>			
4. DATE OF DEATH	Month <b>March</b>	Day <b>9</b>	Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1922</b>			
9. AGE (In years last birthday) <b>36 yrs.</b>		10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Hours <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	11. BIRTHPLACE (State or foreign country) <b>Summerton, S. Carolina</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Reuben Green</b>				
14. MOTHER'S MAIDEN NAME <b>Adeline Regan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>				
16. SOCIAL SECURITY NO. <b>W. W. II</b>		17. INFORMANT <b>Fred Green</b>	Address <b>820 W. Franklin St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b></b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>onc X</b>						
(b) DUE TO <b>Far advanced bilateral cavitary tuberculosis</b>						
(c) DUE TO <b></b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour p. m. 19	Month Doy. Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>January 8, 1957</b> , to <b>March 9, 1959</b> , that I last saw the deceased alive on <b>March 9, 1959</b> , and that death occurred at <b>11:58 A.M.</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R. M. Maculans M.D.</i>				ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		
PHYSICIAN'S (NAME & TYPE) <b>Dr. Edgars M. Maculans, Supt.</b>				DATE SIGNED <b>3-9-59.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-16-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Henryton</i>		ADDRESS <i>578 W. Biiddle</i>	24a. REC'D BY REGISTRAR DATE <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Head</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 To be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

102966

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No.	
<u>Carroll</u>		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		d. STREET ADDRESS	
<u>Glynnville</u>		<u>Life</u>		<u>Glynnville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RE. DEATH ON A FAP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		First	Middle	Last	4. DATE OF DEATH
<u>W</u> C Y E N I A G R I F F E E					<u>March</u> 1 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years on birthday) yrs. Months Days Hours Min
<u>Female</u>		<u>White</u>		<u>1883</u> <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Homework</u>		<u>Home</u>		<u>Md.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>William Griffee</u>		<u>Sorenia Ekronister</u>		<u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (For, no., or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
		<u>422.1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<u>Arterio-Sclerotic C-T disease</u> <u>year</u>			
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour <u>6</u> . m. <u>p</u> . m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Glynnville</u> (County) <u>Md.</u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES J. MARSH</u>		DATE SIGNED <u>3/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-59</u>		22c. NAME OF CEMETERY OR Crematory <u>Glynnfield</u>	
22d. LOCATION (City, town, or county) <u>Glynnville, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Height Glynnville, Md.</u>		ADDRESS <u>Glynnville, Md.</u>		24a. REC'D BY REGISTRAR DATE MAR 5 '59	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02967

Reg. Dist. No.

2973

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10yr. 25days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Harry</b>	Middle <b>Edward</b>	Last <b>Griffin</b>	4. DATE OF DEATH <b>3 5 1959</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-30-83</b>	9. AGE (In years at birthday) <b>75</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Morris Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Susan Dorothy Dill</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO <b>218-09-4442A</b>		17. INFORMANT <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH  422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>with cardiac insufficiency.</b> DUE TO (c) <b>Pneumonia</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>August 1955</b> , to <b>March 5, 1959</b> , that I last saw the deceased alive on <b>March 5, 1959</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>3-5-59</b>					
ACTUAL SIGNATURE <i>Walter Knopp</i>		M.D. <b>Walter Knopp, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3 4 59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Community Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Knopp</i>		ADDRESS <b>411 E. Baltimore St., Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Orion S. Knapp</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112968

2979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>22 yrs. 11 mo. 8 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>1609 E. 29th. St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>John</b>	Middle —	Last <b>Himmel</b>	4 DATE OF DEATH	Month <b>3</b> Day <b>16</b> Year <b>1959</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-75</b>	9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ticket taker at races</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wolfgang Himmel</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Margaretta Durfler</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>YONE</b> Unknown		17. INFORMANT <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute peritonitis</b> <b>561.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Strangulated rectum in left inguinal ring.</b>				INTERVAL BETWEEN ONSET AND DEATH Days	
(b) <b>Old myocardial infarct</b>				Days	
(c) <b>Involutional psychotic reaction.</b>				Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that I attended the deceased from <b>August</b> , 19 <b>55</b> , to <b>3-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-16</b> , 19 <b>59</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Walter Knopp</i>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>3-16-1959</b>	
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/19/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Moreland Memorial</b>	22d. LOCATION (City, town, or county) <b>Baltimore County, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>		ADDRESS <b>Glen Burnie, Md.</b>	24a. REC'D BY REGISTRAR <b>MAR 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haas</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02969

## CERTIFICATE OF DEATH

2941

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Westminster

c. LENGTH OF STAY IN 1b

35 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

216 S. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Westminster

d. STREET ADDRESS

216 S. Main St.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

MARCH 9

1959

5. SEX

Female White

6. COLOR OR RACE

WIDOWED DIVORCED 7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)  
yrs

IF UNDER 1 YEAR

Months

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Days

Hours

Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Howard Zile

14. MOTHER'S MAIDEN NAME

Leannah Stein

Address

Miss Leannah L. Hoffman Westminster, Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Miss Leannah L. Hoffman

INTERVAL BETWEEN  
ONSET AND DEATH

Few minutes

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.

DUE TO

(b)

DUE TO

(c)

Coronary Thrombosis

Arteriosclerosis (General) c 5 yrs  
an Hypertension & myocardial degeneration wereINTERVAL BETWEEN  
ONSET AND DEATH

Few minutes

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from March 8, 1959, to March 9, 1959, that I last saw the deceased alive on March 8, 1959, and that death occurred at 11:30 A.M. from the causes and on the date stated above.ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

ADDRESS (Street, city or town, state)

DATE SIGNED

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(State)

J. E. Myers, Jr., Westminster, Md.

MAR 11 '59

Arthur S. Krause



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02970

2980

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mos. 15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emily Charlotte Boese</b>		First <b>Emily</b>	Middle <b>Charlotte</b>
		Last <b>Boese</b>	Honikel
4. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. DATE OF BIRTH <b>September 22, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Boese</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-24-4583-A</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
C. B. S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 25 1958</b> , to <b>March 10, 1959</b> , that I last saw the deceased alive on <b>March 10, 1959</b> , and that death occurred at <b>12:30PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>3/10/59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Home Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jook County, Ill.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Smith</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 12 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12971

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNIONTOWN</b>		c. LENGTH OF STAY IN lb <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY AUSTIN HORNING</b>		First	Middle
		LAST	Month
4. DATE OF DEATH		Day	Year
<b>MARCH 20 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2/14/1891</b>		9. AGE (In years lost/birthday) <b>68 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BY DAY</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>MOSES HORNING</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH GARVICK</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>220-05-3676</b>		17. INFORMANT Address <b>MRS. MARIA G. HORNING, UNIONTOWN, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <i>Carcinoma of lung</i>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 4, 1959</b> , to <b>Mar 20, 1959</b> , that I last saw the deceased alive on <b>Mar 20, 1959</b> , and that death occurred at <b>11:27 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Julius Chepko</b>		ADDRESS (Street, city or town, state) <b>852 W. Green Street, Baltimore, Md.</b> DATE SIGNED <b>3/20/59</b>	
PHYSICIAN'S NAME (Type) <b>Julius Chepko</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>CHURCH OF GOD</b>		22d. LOCATION (City, town, or county) (State) <b>UNIONTOWN, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D.D. Hartfords, New Windsor, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 24 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Orlina S. Davis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 To be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102972

2982

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Sykesville		c. LENGTH OF STAY IN lb  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCool	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.F.D. 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Angelina	Middle Lillian	Last IACOVONE
4. DATE OF DEATH	Month 3	Day 17	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1921
9. AGE (In years from birthdate) 37 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 MRS. Days	12. IF UNDER 24 MRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	10b. KIND OF BUSINESS OR INDUSTRY Rooming House	11. BIRTHPLACE (State or foreign country) W.Va.	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Iacovone, Sr		14. MOTHER'S MAIDEN NAME Margaret Silcotte (Iacovone)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-48-3213	17. INFORMANT Frank Iacovone, Jr. Keyser, W.Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 Melanc carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalization DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 months Cirrhosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 1959, to <u>March</u> , 1959, that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Bertie A. S.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) P. Grand R. Gage		M.D. 37 Central Avenue	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/59	22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas
22d. LOCATION (City, town, or county) Keyser		(State) W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Knobell, Keyser, W.Va.		24a. REC'D BY REGISTRAR DATE MAR 23 '59	24b. REGISTRAR'S SIGNATURE John S. Thomas



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2983

## CERTIFICATE OF DEATH

02973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore,	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Guy Cookson Nursing Home	d. STREET ADDRESS 3510 Grantley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Marien	Middle James	4. DATE OF DEATH Month March Day 8, Year 1959
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY school teacher	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Dean Janney		14. MOTHER'S MAIDEN NAME Marion Rowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Mrs. Granville H. Hibberd Address New Windsor, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>42 d. l.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO <u>years</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-7</u> , 19 <u>59</u> to <u>3-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>59</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>3-8-59</u>			
ACTUAL SIGNATURE <u>James T. Marsh</u>	M.D.		
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>	<u>Baltimore, Md.</u>		
22a. BURIAL CREMATION, BURIAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS <u>1900 Eutaw Place</u>	24a. REC'D BY REGISTRAR DATE <u>Arthur S. Krause</u> MAR 10 '59
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2984

## CERTIFICATE OF DEATH

02974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>R.D. # 2</b>	
3. NAME OF DECEASED (Type or print)	First <b>ERNEST</b>	Middle <b>H.</b>	Last <b>JENKINS</b>
4. DATE OF DEATH	Month <b>MARCH</b>	Day <b>27,</b>	Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1875</b>
9. AGE (In years last birthday) <b>83 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Hanson Jenkins</b>	14. MOTHER'S MAIDEN NAME <b>Annie R. Hiltabridle</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT <b>Mr. Holly Jenkins, same</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Congestive heart failure, arteriosclerosis.</b> (b) <b>generalized, cerebral hemorrhage.</b> DUE TO (c) <b>deceased alone</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Five days to 27 March 1959</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>Jan</b>	Day <b>19</b>	Year Not while at work <input type="checkbox"/> at work <input type="checkbox"/>
20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>27 March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>27 March</b> , 19 <b>59</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>Lippsville, Md 27 March</b>	DATE SIGNED <b>27 March 1959</b>	
ACTUAL SIGNATURE <b>Howard E. Hall</b>	M.D.		
PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-30-1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Messiah Lutheran</b>	22d. LOCATION (City, town, or county) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. N. Waltz,</b>	ADDRESS <b>Winfield, Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 31 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1 OS AL & ATTEND TO FUNERALCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by the hospital or attending physician. To this certificate has been attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2985

## CERTIFICATE OF DEATH

02975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Mt. Airy</b>		d. STREET ADDRESS <b>R.D. 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>OLIVER</b>	Middle <b>O.</b>	Last <b>KEEFER</b>	4. DATE OF DEATH	Month <b>MARCH</b>	Day <b>24,</b>	Year <b>19 59</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-13-1883</b>	9. AGE (In years last birthday) <b>76 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles W. Keefer</b>				14. MOTHER'S MAIDEN NAME <b>Anna R. Bart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-16-2065</b>		17. INFORMANT <b>Mrs. Florence Keefer, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Probably Generalized Carcinoma</b>				Acute Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 9, 1959</b> to <b>Mar. 24, 1959</b> , that I last saw the deceased alive on <b>Mar. 8, 1959</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. M. Van Pelt</b>		ADDRESS (Street, city or town, state) <b>211 Ellery Rd</b>					
PHYSICIAN'S NAME (Type) <b>C. M. Van Pelt</b>		DATE SIGNED <b>3-24-59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-27-1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Prospect</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. L. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2986

## CERTIFICATE OF DEATH

02976

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (rural)</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> City 311	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d STREET ADDRESS <b>110 N. Essex Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Thomas</b>	Lost <b>(KREPPEL) Kreppel</b>	4. DATE OF DEATH <b>March 28 1959</b>	Month Year	Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-72</b>	9. AGE (In years lost birthday) <b>86 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>solderer</b>		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>John Kreppel (KREPPEL)</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>/?</b>		16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>Springfield State Hospital (Record)</b>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost } (b) <b>Arteriosclerotic heart disease; Auricular fibrillation, 7 y.</b> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with disturbances of growth, metabolism and nutrition with senile brain disease with psychotid reaction,</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Hour o. m. p. m. <b>xx</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> <b>xx</b> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>xx</b>	20f. (City or town) <b>x XXX</b>	(County)	(State)
21. I certify that I attended the deceased from <b>August 1, 1955</b> , to <b>March 28, 1959</b> , that I last saw the deceased alive on <b>March 28, 1959</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>					
DATE SIGNED <b>Walter Knopp</b>					
ACTUAL PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>					
Sylmar, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 3-31-59</b>	22b. DATE THEREOF <b>901 S. CONKLING ST.</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>HOLY REDEEMER CEM</b>	22d. LOCATION (City, town, or county) <b>4430 BELAIR Rd. BALTO., MD.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lawrence S. Geiles</b>		ADDRESS <b>BALTIMORE, MD.</b>	24a. REC'D BY REGISTRAR <b>MAR 30 '59</b>	24b. REG STAR'S SIGNATURE <b>Cirius S. Knapp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN—The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Filed 4-3-59 et

## CERTIFICATE OF DEATH

02977

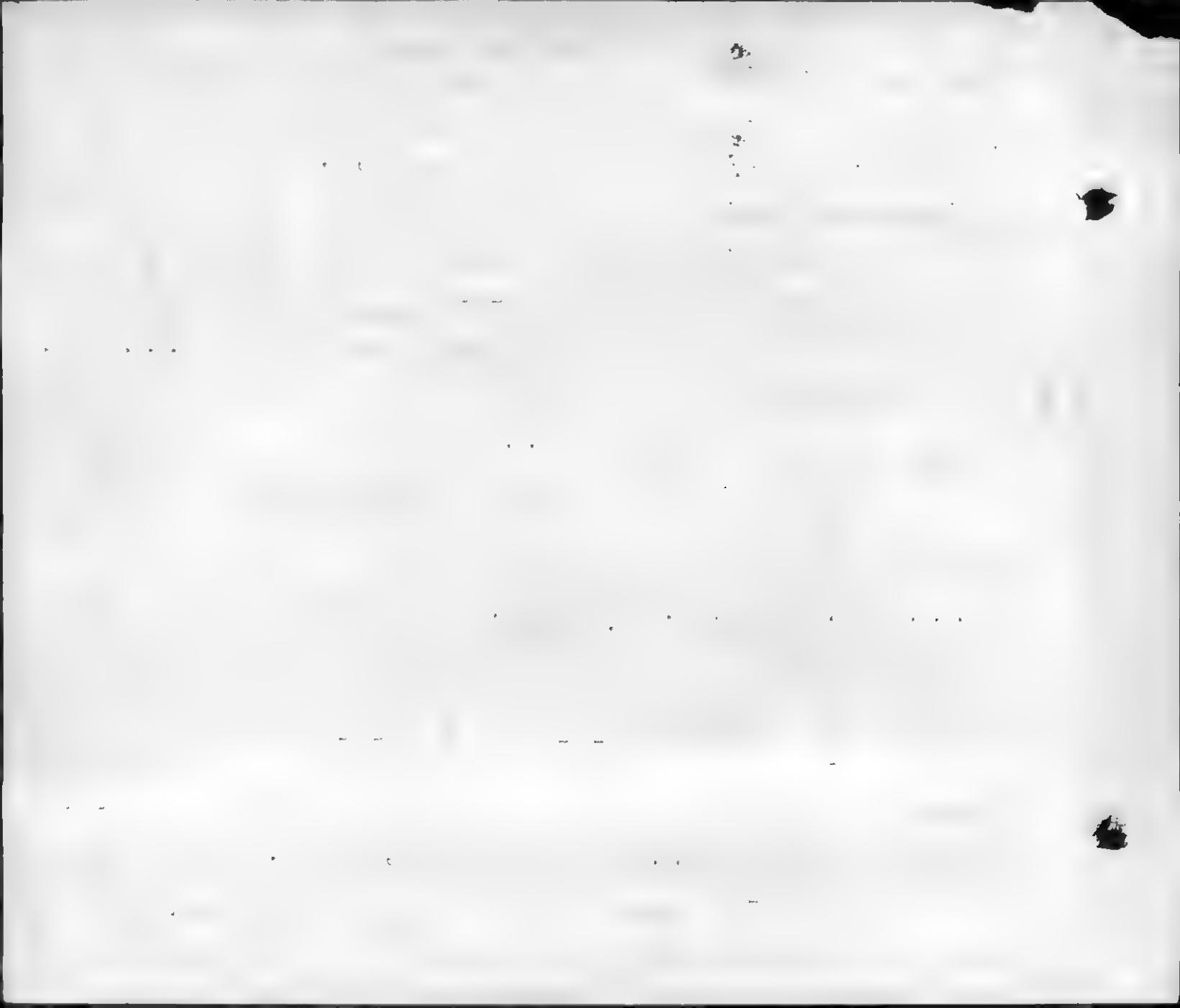
Reg. Dist. No.

2987

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10 m 15 d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24, Md.</b>		d. STREET ADDRESS <b>3404 Harmony Court</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Katherine</b>		First	Middle	Lost	4. DATE OF DEATH <b>3 28 1959</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>4-18-75</b>	9. AGE (In years last birthday) <b>84 83 yrs</b>	IF UNDER 1 YEAR <b>84</b>	IF UNDER 24 HRS. Months <b>84</b>	Days <b>83</b>	Hours <b>00</b>
FATHER'S NAME <b>JOSEPH DOUBEK</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. natur.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Xunka S.S. Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with disturb. of metabolism, growth or nutrition with senile brain disease with psych. reaction</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5-13-</b> , 19 <b>58</b> to <b>3-27-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-27-</b> , 19 <b>59</b> , and that death occurred at <b>1:03 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Edmund Lusthaus</i> M.D. Springfield State Hospital							ADDRESS (Street, city or town, state) <b>Sykesville, Maryland.</b>	
DATE SIGNED <b>3-28-59</b>								
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE 6, MD.</b>						
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22f. DATE THEREOF <b>3 - 31 - 59</b>		22g. NAME OF CEMETERY OR CREMATORIUM <b>HOLY REDEEMER</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank L. Jackson 900 W. Baltimore St.</i>		ADDRESS <i>Baltimore Md.</i>		24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REG STAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2988

## CERTIFICATE OF DEATH

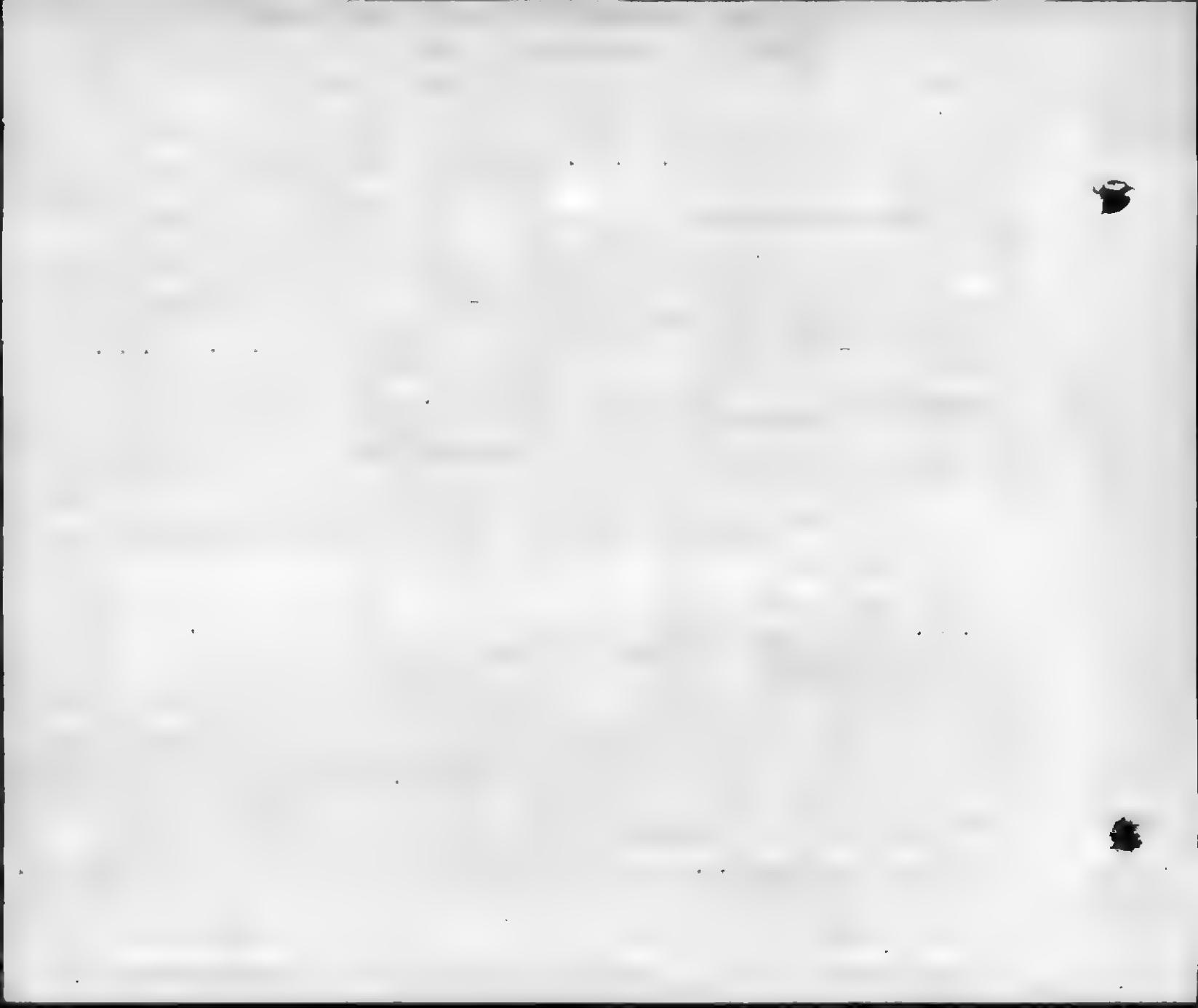
02978

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>lyr. lm. ld.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>310 Herring Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Thomas</b>	Last <b>Lanham</b>	4. DATE OF DEATH <b>3 25 1959</b>	Month <b>3</b>	Day <b>25</b>	Year <b>19 59</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-24-66</b>	9. AGE (in years last birthday) <b>92 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	IF UNDER 24 HRS Min. <b>0</b>
8. MARITAL STATUS WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Prince Geo. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephen Lanham</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Henry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Pneumonia</b> <b>493 X</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>two weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. associated with senile brain disease with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 21, 1958</b> , to <b>March 25, 1959</b> , that I last saw the deceased alive on <b>March 25, 1959</b> , and that death occurred at <b>4:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walter Knopp, M.D.</b> <b>3-20-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b> Springfield State Hospital, Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <b>Charles E. Schimunek Funeral Home 3331 Brehms Lane</b>				24a. REC'D BY REGISTRAR <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Knopp</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

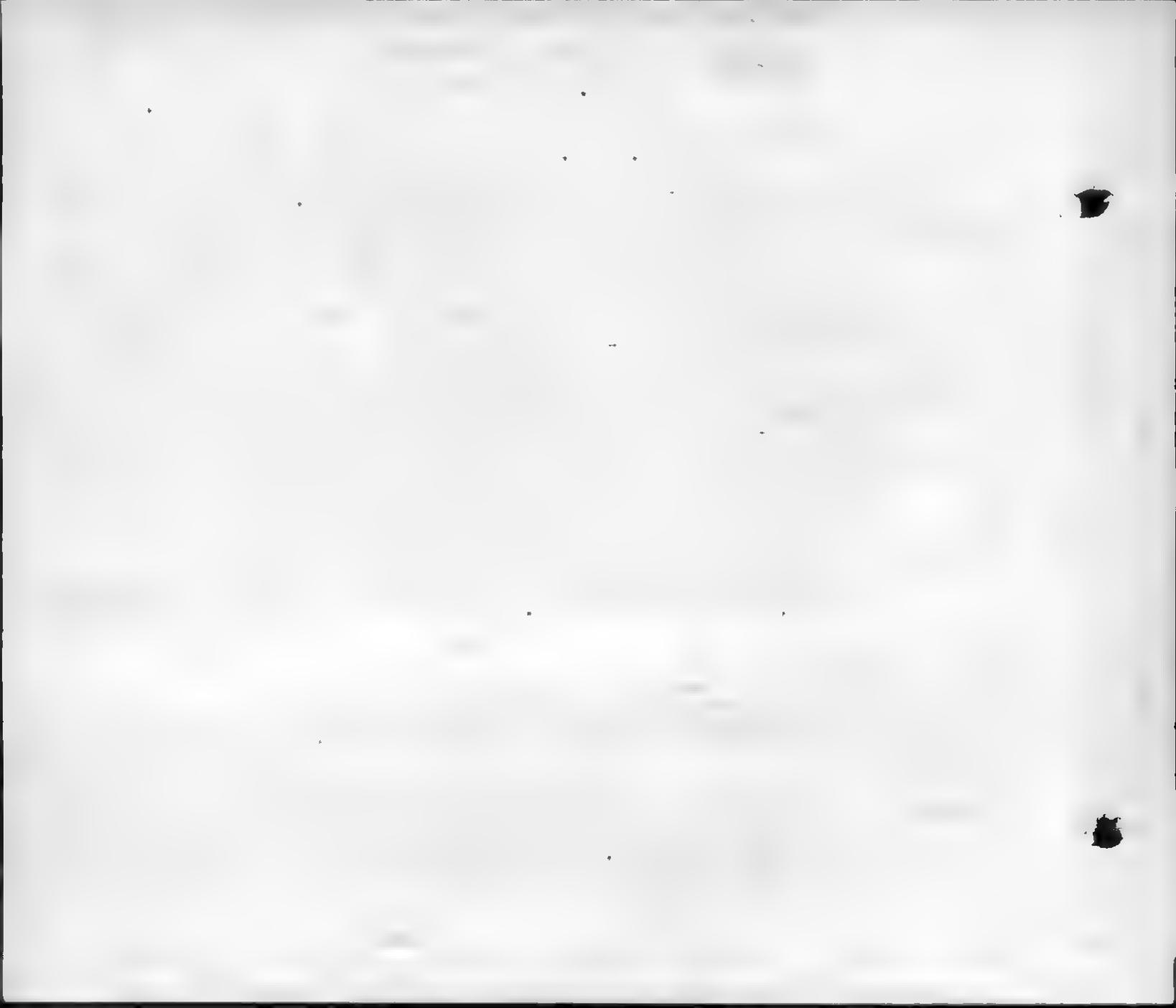
CERTIFICATE OF DEATH

02979

Reg. Dist. No.

2989

1. PLACE OF DEATH o COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Balt. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 10yrs. 11mos. 23days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2111 Ridgehill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Benjamin	Middle Lassen	Lost	4. DATE OF DEATH March 22, 1959	Month March	Day 22	Year 1959
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1872	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement worker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? Unknown		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO - - -		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis, simple deterioration.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield	(County)	(State)		
21. I certify that I attended the deceased from March 7, 1959, to March 22, 1959, that I last saw the deceased alive on March 22, 1959, and that death occurred at 4:10 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Agustin del Campo</i>							ADDRESS (Street, city or town, state) Springfield Hospital	DATE SIGNED 3/23/59
PHYSICIAN'S NAME (Type)		Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-25-58	22c. NAME OF CEMETERY OR CREMATORIUM West Baltimore	22d. LOCATION (City, town, or county) Baltimore, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Howell</i>		ADDRESS Sykesville, Md.	24a. REC'D BY REGISTRAR MAR 30 59	24b. REGISTRAR'S SIGNATURE Arthur L. Turner				



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

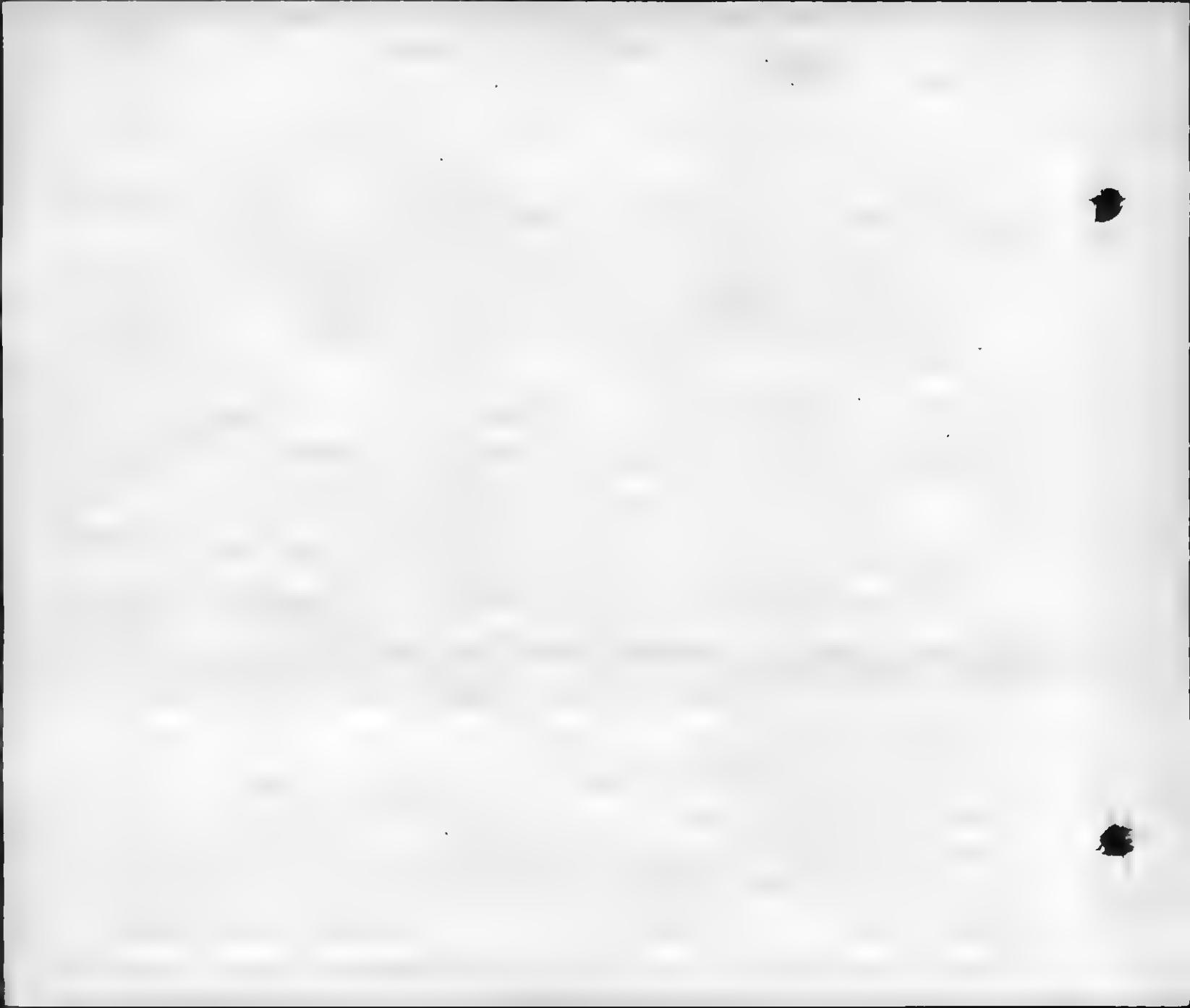
102980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION MILLS</b>		c. LENGTH OF STAY IN 1b <b>2 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 2 WESTMINISTER MD</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XUNION MILLS</b>	
3. NAME OF DECEASED (Type or print) <b>FERN FRANCES MCAREE</b>		d. STREET ADDRESS <b>RFD 2 WESTMINISTER MD</b>	
5. SEX <b>FEMALE</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>FEB. 15-1894</b>		9. AGE (In years last birthday) <b>65 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS ACKERMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>MRS. FERN E. KOWALL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Coronary Thrombosis</b> (b) DUE TO <b>Hypertension</b> (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/20/56</b> , 19 <b>56</b> , to <b>March 30, 1959</b> , that I last saw the deceased alive on <b>Nov 25</b> , 19 <b>58</b> , and that death occurred at <b>1A M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Manchester, Md</b>	
ACTUAL SIGNATURE <b>W.H. Ford</b>		DATE SIGNED <b>3/30/59</b>	
PHYSICIAN'S NAME (Type) <b>W.H. Ford MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-2-1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>LORRAINE CEN.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Fern H. Ford 7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>John S. McLean</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02981

2991

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 6,230 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3000-Seabury Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Margaret	Middle McDaniel	Last McDaniel	4. DATE OF DEATH March	Month March	Day 15	Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 11, 1906	8. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Brooks				14. MOTHER'S MAIDEN NAME Laura Curtis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Margaret McDaniels		Address 3000 Seabury Road		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular insufficiency</u>  002 X DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost! (b) <u>Atelectasis of the left lung and shifting</u> of the heart and mediastinum  (c) <u>Far Advanced Pulmonary Tuberculosis</u>  INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Henryton, Maryland	(County)	(State)		
21. I certify that I attended the deceased from December 10, 1951, to March 15, 1959, that I last saw the deceased alive on March 15, 1959, and that death occurred at 4:05A.M. from the causes and on the date stated above.  ACTUAL SIGNATURE <u>E. M. MacLaren, M.D.</u> M.D.								
22a. PHYSICIAN'S NAME (Type)		22b. DATE THEREOF 3-18-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn		22d. LOCATION (City, town, or county) Balt. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles B. Lewis</u>		ADDRESS 1634 N. Broadway Balt. 13, Md.		24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02982

2942

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>45 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		d. STREET ADDRESS <i>158 Penna Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>158 Penna Ave.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>CAROLINE</i>	Middle <i>VIRGINIA</i>	Last <i>Mc KINNEY</i>	4. DATE OF DEATH <i>March 29 1959</i>	Month <i>March</i>	Day <i>29</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1878</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Timberville, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Braswell P. Neff</i>		14. MOTHER'S MAIDEN NAME <i>Mary Frances Leijster</i>		Address <i>Westminster, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. Andrew P. McKinney</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 3-21-59</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral thrombosis</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first <i>Cardio-vascular disease</i> DUE TO <i>(b) Senile Sx</i>						5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>none</i>						5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-29</i> , 19 <i>59</i> , to <i>3-29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3-29</i> , 19 <i>59</i> , and that death occurred at <i>9:45 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Westminster, Maryland</i>					
ACTUAL SIGNATURE <i>C. E. Billingslea</i>		DATE SIGNED <i>3-30-59</i>					
PHYSICIAN'S NAME (Type) <i>C. E. Billingslea</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 1, 59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Westminster Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Westminster, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Westminster, Md.</i>		ADDRESS		24a. REG'D BY REGISTRAR DATE <i>APR 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2992

## CERTIFICATE OF DEATH

102983

Reg. Dist. No. 74

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 will be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>199 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d STREET ADDRESS <b>RFB #2, Box 284</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Nicholas</b>	Middle <b>Longsworth</b>	Last <b>Miles</b>	4. DATE OF DEATH	Month <b>March</b>	Day <b>5</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1906</b>	9. AGE (In years lost birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Gaithersburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Miles</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stewart</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-6930</b>		17. INFORMANT <b>Mary Chappell - 1320 Fairmount St., N.W.</b>		Address <b>Wash., D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b>		DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>002X</b>		DUE TO <b>Far advanced bilateral pulmonary tbc.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>August</b>	Day <b>18</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Henryton</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>August 18, 1958</b> , to <b>March 5, 1959</b> , that I last saw the deceased alive on <b>March 5, 1959</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>3-5-59</b>	
MEDICAL CERTIFICATION <b>Signature</b>		<b>Edgars M. Marulans, M. D.</b>		<b>Henryton, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Edgars M. Marulans, M. D.</b>		Henryton State Hospital					
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 18, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Emory Grant Cemetery Co. Inc.</b>	22d. LOCATION (City, town, or county) <b>Montgomery Co. Md.</b>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert J. Snodder Rockville</b>	ADDRESS <b>10017 Rockville Rd.</b>	24a. REC'D BY REGISTRAR <b>Mar 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

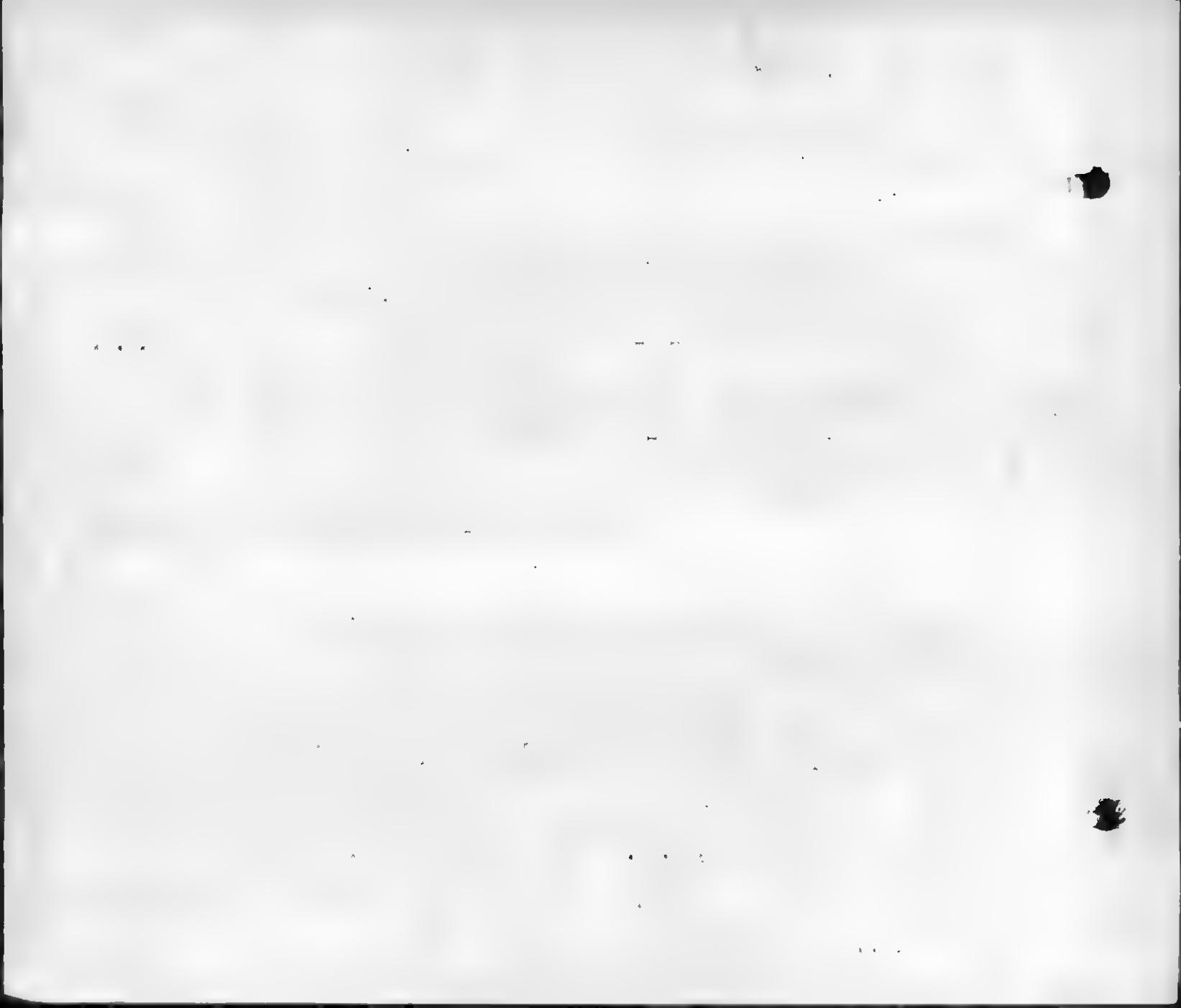
## 2993

## CERTIFICATE OF DEATH

12984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. LENGTH OF STAY IN lb <b>ly 1m 22d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lena</b>	Middle <b></b>	Last <b>Miller</b>
4. DATE OF DEATH	Month <b>March</b>	Day <b>24</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 18, 1870</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Johann ?</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Springfield State Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH Days <b></b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Arteriosclerotic Cardio-vascular disease</b>		Years <b></b>	
DUE TO  (b) <b>Generalized arteriosclerosis</b>		Years <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  <b>Chronic brain syndrome associated with senile brain disease</b>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b></b>	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>February</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b>Springfield</b>	(County) <b>Montgomery</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>February 2, 1958</b> , to <b>March 24, 1959</b> , that I last saw the deceased alive on <b>March 23, 1959</b> , and that death occurred at <b>12:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elisabeth Knopp</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Elisabeth Knopp, M. D.</b>		DATE SIGNED <b>3/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/27/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		24a. ADDRESS <b></b>	24b. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Chilton &amp; Thompson</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 F 1 . . . + 3-26-59 et

## CERTIFICATE OF DEATH

02985

Reg. Dist. No.

2943

1. PLACE OF DEATH  
o COUNTY

Carroll County

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Westminster

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Dr. W. Y. Speicher's Office

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

## a. STATE

Md.

## b. COUNTY

Baltimore

## d. STREET ADDRESS

1206 Havenwood Ed.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

## 3. NAME OF

First KENNETH

Middle S.

Last MOWLDS

(Type or print)

4. DATE  
OF  
DEATHMonth March Day 21, 1959  
Year

## 5. SEX

male

## 6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

Feb. 22, 1903

9. AGE (In years  
last birthday)56 yrs.  
Months Days Hours Min.10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

President

## 10b. KIND OF BUSINESS OR INDUSTRY

Heavy Chemicals

## 11. BIRTHPLACE (State or foreign country)

Delaware

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Eugene Mowlds

## 14. MOTHER'S MAIDEN NAME

Christine Mackenzie

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

no

## 16. SOCIAL SECURITY NO

216-03-5010

## 17. INFORMANT

Mrs. Bernadette Mowlds - 1206 Havenwood Rd.,  
Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a).

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

{ (b)

DUE TO

(c)

Coronary artery disease

INTERVAL BETWEEN  
ONSET AND DEATH

3 yrs.

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

none

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19 p.m.20d. INJURY OCCURRED  
While at work  Not while at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from March 7, 1958 to March 21, 1959, that I last saw the deceased alive on December 18, 1958, and that death occurred at \_\_\_\_\_, M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE George W. Murgatroyd, Jr., M.D. 1127 St. Paul St. Balto. 2.  
PHYSICIAN'S  
NAME (Type) Dr. George W. Murgatroyd, Jr., M.D. 1127 St. Paul St. Balto. 2, Md.22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

3/25/59

## 22c. NAME OF CEMETERY OR CREMATORIUM

Druid Ridge Cem.

## 22d. LOCATION (City, town, or county)

Pikesville, Md.

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

John J. Lickener

## ADDRESS

800

## 24a. REC'D BY REGISTRAR

MAR 24 '59

## 24b. REGISTRAR'S SIGNATURE

Arthur S. French



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102986

2994

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN lb

8 y 1 m 12 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Springfield State Hospital

## 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore 13, Md.

3. NAME OF DECEASED  
(Type or print)First  
GeorgeMiddle  
IgnatiusLast  
Muzdakis

4. DATE OF DEATH

Month  
3Day  
21Year  
1959

## 5. SEX

M

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

1 - 12 - 03

## 9. AGE (In years on birthday)

56 yrs

## 10. IF UNDER 1 YEAR

Months  
0

## 11. IF UNDER 24 HRS

Days  
0Hours  
0Min  
0

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Lithuania

## 12. CITIZEN OF WHAT COUNTRY?

unkn

## 13. FATHER'S NAME

Stanley Muzdakis

## 14. MOTHER'S MAIDEN NAME

Barbara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  
(If yes, give war or date of service)

no

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

Springf. Hospital Records

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Bronchopneumonia

## INTERVAL BETWEEN ONSET AND DEATH

days

491X

## DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH IN REVERSE ORDER OF THEIR IMPORTANCE IN PART I(a)

Schizophrenia, paranoid type, fracture of skull with post-traumatic epilepsy (old fracture)

19. WAS AUTOPSY PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from 10-20-54 to 3-21-59, that I last saw the deceased alive on 3-21-59, and that death occurred at 1:40 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

## ACTUAL SIGNATURE

## PHYSICIAN'S NAME (Type)

Edmund Lusthaus M.D.

Sykesville, Maryland

3-21-59

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF  
3/28/5922c. NAME OF CEMETERY OR CREMATORIUM  
Holy Cross Cemetery22d. LOCATION (City, town, or county)  
Baltimore Md. (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Leonard J. Kuck S. 305 Harford

## ADDRESS

24a. REC'D. BY REGISTRAR  
MAR 26 1959  
DATE

24b. REGISTRAR'S SIGNATURE  
Arthur S. Kraus



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102987

2995

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	c. LENGTH OF STAY IN 1b <i>4 1/2 yrs</i>	b. COUNTY <i>Carroll County</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print)	First <i>George</i>	Middle <i>David</i>	Last <i>Myerly</i>		
4. DATE OF DEATH Month <i>March</i>	Month <i>15</i>	Day <i>1959</i>	Year		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 6, 1866</i>		
9. AGE (In years last birthday) <i>92 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Balt Co. Md</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>Austria</i>		
13. FATHER'S NAME <i>William Henry Myerly</i>	14. MOTHER'S MAIDEN NAME <i>Eleanor Elizabeth Schaffier</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; if yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO <i>220-05-9501</i>	17. INFORMANT <i>George D. Myerly - Manchester Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriovenous Hypocondriac</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriovenous Cardiac Vasculitis Disease</i> (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hampstead, Maryland</i>	20f. (City or town) <i>Hampstead</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Nov 13</i> , 1957, to <i>March 15</i> , 1959, that I last saw the deceased alive on <i>3-15-59</i> , 1959, and that death occurred at <i>11:15 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Joseph E. Bush</i>	ADDRESS (Street, city or town, state) <i>Hampstead, Maryland</i>			DATE SIGNED <i>3-15-59</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/15/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lutheran Cemetery</i>	22d. LOCATION (City, town, or county) <i>Waugetown, Carroll Md.</i>	(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin G. Yipton</i>	ADDRESS <i>Hampstead Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 19 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retrained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this copy has been executed by the attending physician and completely filled in, copy the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy has been executed by the attending physician and completely filled in, copy the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

02958

**CERTIFICATE OF DEATH**

2996

Reg. Dist. No. ....

**1. PLACE OF DEATH**

COUNTY Carroll

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)

TOWN Louisville

MARYLAND

LENGTH OF STAY  
(In this place)

4 weeks

HOSPITAL/INSTITUTION OR  
STREET ADDRESS**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland

COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Louisville

STREET ADDRESS

(If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**

(First)

(Middle)

(Last)

Almetta

Owens

**4. DATE  
OF  
DEATH**

March 10

1959

**5. SEX****6. COLOR OR  
RACE**

Female

White

**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)**

Married

**8. DATE OF BIRTH**

February 2-6-1884

75

**9. AGE last birthday**

75

**IF UNDER 1 YEAR**

Months

**IF UNDER 24 HRS.**

Days

Hours

Min.

**10e. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Housewife

**10b. KIND OF BUSINESS  
OR INDUSTRY**

Home

**11. BIRTHPLACE** (State or foreign country)

Tenn.

**12. CITIZEN OF WHAT  
COUNTRY?**

U.S.A.

**13. FATHER'S NAME**

James Gandy

**14. MOTHER'S MAIDEN NAME**

Frances Miller

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**

(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

**16. SOCIAL SECURITY NO.**

-

**17. INFORMANT & ADDRESS**

William Miller, 123 Main St., Louisville, Ky.

**INTERVAL BETWEEN  
ONSET AND DEATH**

1 hr.

5 days

**18. MEDICAL CERTIFICATION****IMMEDIATE CAUSE**

(A)

Pulmonary Embolism

**DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.**

(B)

Lymphangitis and sub-clavian thrombosis  
of right arm

(C)

Arteriosclerotic cardio-vascular  
disease**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES  NO **21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)****21e. INJURY OCCURRED  
While  
at work  Not while  
at work** **21f. HOW DID INJURY OCCUR?****M.****DATE****22. I hereby certify that I attended the deceased from.....12-29-.....19.....56, to.....3-10.....19.....59....., that I last saw the deceased****alive on.....3-10-.....19.....59....., and that death occurred at.....1 P.M., from the causes and on the date stated above.****ADDRESS (Street, city, town, or county)****DATE SIGNED****Martin E. Strobel M.D. 118 Main St. Roisterstown, Md. 3-10-59****23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)****DATE THEREOF**

3-13-59

**NAME OF CEMETERY OR CREMATORIUM**

Baltimore

**LOCATION (City, town, or county)**

Baltimore

(State)

**24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE****25. FUNERAL DIRECTOR'S SIGNATURE****ADDRESS**

MAR 13 '59

Cirius S. Kraus

John E. Strobel

123 Main St., Louisville, Ky.

**DATE**

1-1-  
464

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2997

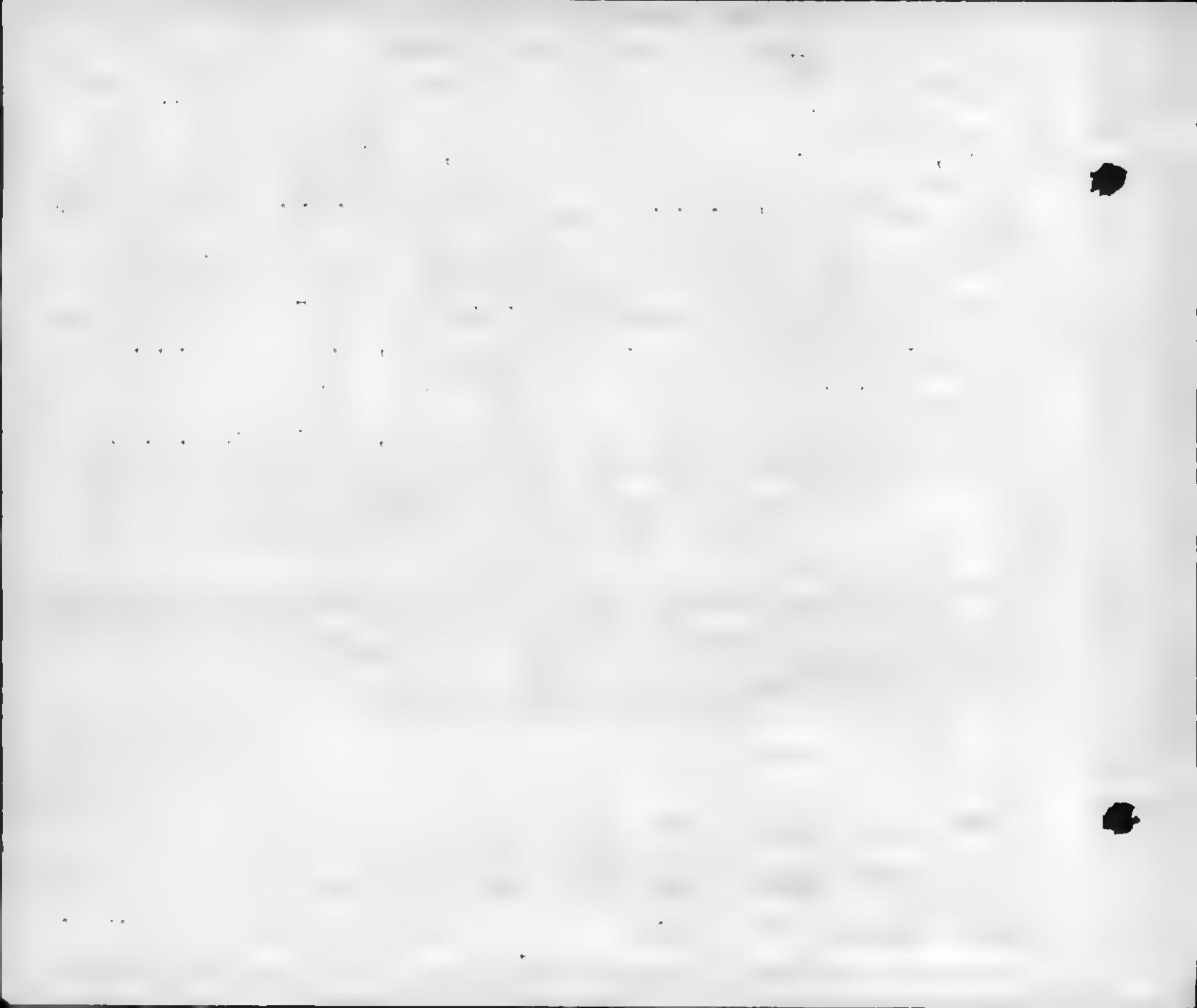
## CERTIFICATE OF DEATH

02989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.7				d. STREET ADDRESS Westminster, Md. R.D.7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ronald	Middle Wayne	Last Phillips	4. DATE OF DEATH	Month March 24, 1959	Day 19	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1958	9. AGE (In years from birthday) 3 yrs.	IF UNDER 1 YEAR Months 3	Days 15	IF UNDER 24 HRS. Hours 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nothing - Infant		10b. KIND OF BUSINESS OR INDUSTRY Nothing - Infant		11. BIRTHPLACE (State or foreign country) Gettysburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bennie Phillips		14. MOTHER'S MAIDEN NAME Shirley Presnell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Bennie Phillips, Westminster, Md. R. D. 7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Meningoencephalitis with infection</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
(c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Hydrocephalus</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 9</u> , 1958, to <u>Mar 26</u> , 1959, that I last saw the deceased alive on <u>Dec 27</u> , 1958, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Leah Maitland</i>		PHYSICIAN'S NAME (Type) <i>LEAH MAITLAND</i>		50 Maple Ave Littlestown, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Richard A. Little</i>		ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15M  
BM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02990

Reg. Dist. No.

2998

### 1. PLACE OF DEATH

a. COUNTY

Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN TB

2 yrs. 7 mos. 25 days

MARYLAND

### 2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Whitehall

### d. STREET ADDRESS

RD#2

e. IS RESIDENCE ON A FARM? YES  NO

### Springfield State Hospital

### 3. NAME OF DECEASED (Type or print)

First  
Mildred

Middle  
Cecelia

Last  
Powers

DATE OF DEATH

Month  
March

Day  
25,

Year  
19 59

### 4. SEX

Female

COLOR OR RACE  
White

### 5. MARRIED

### NEVER MARRIED

### 6. DIVORCED

### DATE OF BIRTH

August 17, 1903

### 7. AGE (In years from birthday)

55

Yrs

### 8. IF UNDER 1 YEAR

Months

Days

### 9. IF UNDER 24 HRS

Hours

Min

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse's Aide

### 10b. KIND OF BUSINESS OR INDUSTRY

### 11. BIRTHPLACE (State or foreign country)

Maryland

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

John E. Powers

### 14. MOTHER'S MAIDEN NAME

Margaret E. Dunn

### 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No -

### 16. SOCIAL SECURITY NO.

218-18-8437

### 17. INFORMANT

Address

## Springfield State Hospital Records

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

460.0

### DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY  
C.B.S. assoc. with conv. disorder without qualifying phrase.  
PERFORMED?  
YES  NO

### 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

### 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

### 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

### 20d. INJURY OCCURRED While at work Not while at work

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

James T. Marsh, M.D.

DATE SIGNED

3/26/59

### EXAMINER'S NAME (Type)

Burial

DATE THEREOF  
REMOVAL (Specify)  
3/30/59

### 22c. NAME OF CEMETERY OR CREMATORIUM

New Cathedral Cemetery Baltimore, Maryland

### 22d. LOCATION (City, town, or county)

(State)

### 24a. REC'D BY REGISTRAR

MAR 30 '59

### 24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

### 23. FUNERAL DIRECTOR'S SIGNATURE

John A. Moran—3000 E. Baltimore St.

### ADDRESS

DATE



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 days after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02991

2999

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN lb 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Manison	d. STREET ADDRESS Old Westminster Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Effie	First Lurena	Middle Randall	Last Month Day Year March 16, 1959 19				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1875				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Penns.				
13. FATHER'S NAME George Montgomery		14. MOTHER'S MAIDEN NAME Mary E. Garrett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Charles Randall, Finksburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443X		INTERVAL BETWEEN ONSET AND DEATH 2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertensive Arteriosclerotic C-V Disease (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none					
20c. TIME OF INJURY Hour a. m. p. m.	Month none	Day 19	Year 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) none	(County)	(State)
21. I certify that I attended the deceased from _____		2-3-50		19, to 3-16-59, 19, that I last saw the deceased alive on 3-15-59, 19, and that death occurred at 11 A.M., from the causes and on the date stated above		ADDRESS (Street, city or town, state) 6 Hanover Rd.	
ACTUAL SIGNATURE D. D. Coples					DATE SIGNED 3-17-59		
PHYSICIAN'S NAME (Type) D. D. Coples, M. D.		Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 19, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Finksburg Cemetery	22d. LOCATION (City, town, or county) Finksburg, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS	24a. REC'D BY REGISTRAR MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause			
		DATE					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02992

FOR STATE  
HEALTH DEPT.

3009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cassadee</i>	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) b. STATE <i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Sykesville</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reistersztown</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sprngfield State Hospital</i>	d. STREET ADDRESS <i>Nicodemus</i>
3. NAME OF DECEASED (Type or print)	First ANNIE Middle RAE
4. DATE OF DEATH Month Mar Day 20 Year 1959	5. SEX Female
6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1884	9. AGE (in years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Rosper Alt</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Silver</i> Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 711-11-1111
17. INFORMANT Hospital	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Asphyxia - Mechanical</i> (c) <i>Aspirated Vomititus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterio sclerotic heart disease</i>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Aspirated Vomititus</i>	20c. TIME OF INJURY Month Day, Year Hour 1:00 p.m. 3-20 1959 at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) S.S.H
20f. (City or town) Sykesville	20g. (County) Caroline
20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	DATE SIGNED 3/21/59
ACTUAL SIGNATURE <i>James L. Marsh</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <i>James T. Marsh</i>	22d. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 23, 1959	22c. NAME OF CEMETERY OR CREMATORIAL All Saints
22d. LOCATION (City, town, or county) Reistersztown, Md	22e. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Berryman &amp; Sons</i>	24a. ADDRESS Registersztown
	24b. REC'D BY REGISTRAR DATER 24 '59
	24c. REGISTRAR'S SIGNATURE <i>Arthur L. Knott</i>

■ DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02993

3001

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN lb <b>2 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		d. STREET ADDRESS <b>RURAL 10X-2 JOHNSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ALEXANDER NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CORA</b>		First <b>MAY</b>	Middle <b>REPP</b>	4. DATE OF DEATH <b>MARCH 19 1959</b>	Month <b>MARCH</b>	Day <b>19</b>	Year <b>1959</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/1880</b>	9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JACOB H DIELL</b>		14. MOTHER'S MAIDEN NAME <b>CLARA ELLEN SNOOK</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NU</b>		17. INFORMANT <b>C.W.REPP FREDERICK, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		CERITIFICATION <i>Elizabth Thompson</i>		Cerebral Paralysis		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)			
21. I certify that I attended the deceased from <b>1959</b> to <b>1959</b> that I last saw the deceased alive on <b>1959</b> , and that death occurred at <b>1959</b> A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Union Bridge, Maryland</i>		DATE SIGNED <i>March 20, 1959</i>	
ACTUAL SIGNATURE <i>J. H. MESSLER</i>		PHYSICIAN'S NAME (Type) <b>J. H. MESSLER, M.D.</b>					
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/22/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BEAVER DAM CEM</b>		22d. LOCATION (City, town, or county) <b>FREDERICK COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Hartley, Union Bridge, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Arthur S. Traas MAR 24 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02994

3002

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institutions Residence before admission) a. STATE Maryland		b. COUNTY Balti.City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10mos.19days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3732 Roland Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Emma	Middle Brennan	Last Rowley	4. DATE OF DEATH March 5,	Month March	Day 1959	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1881		9. AGE (in years last birthday) 7 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME - Rowley		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH Years		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arteriosclerotic heart disease							
(b) DUE TO		Generalized arteriosclerosis					Years		
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C. B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain dis. with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from April 16, 1958, to March 5, 1959, that I last saw the deceased alive on March 4, 1959, and that death occurred at 1:15A.M., from the causes and on the date stated above.							ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D. Springfield State Hospital					DATE SIGNED 3/5/59		
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn		22d. LOCATION (City, town, or county) Woodlawn, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

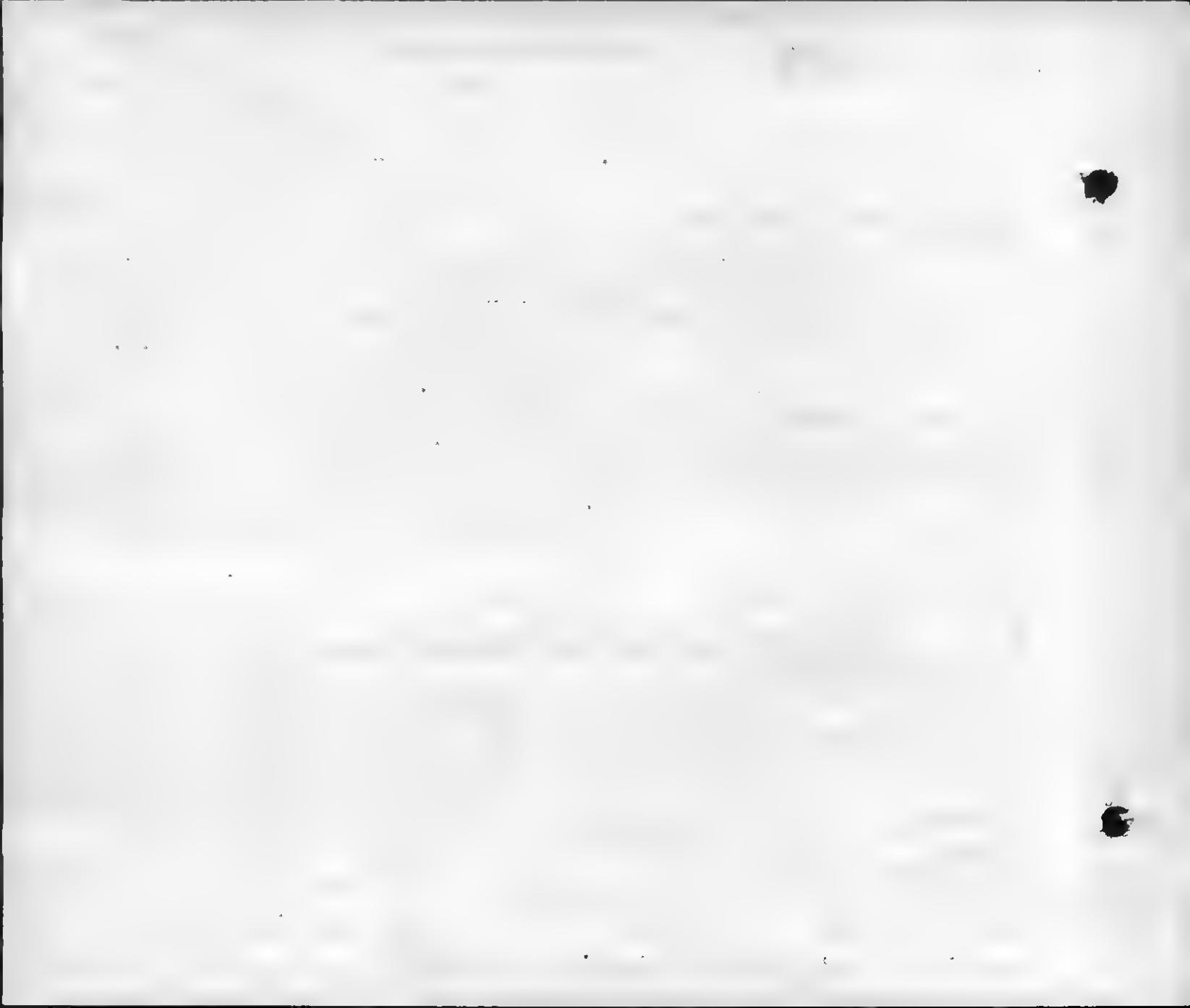
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon copy, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02995	
3003					CERTIFICATE OF DEATH					Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-- Sykesville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS Gaither Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARGIE	Middle RICE	Last	4. DATE OF DEATH March 20, 1959	Month	Day	Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1919	9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert L. Taylor					14. MOTHER'S MAIDEN NAME Mary E. Wright						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Kenneth H. Rice, same			Address			
18. CAUSE OF DEATH [Enter only one cause per line, far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.0 DUE TO Primary Carcinoma of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 1 year?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Medical history										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>58</u> , to <u>3-20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 20</u> , 19 <u>59</u> , and that death occurred at 4:00 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <u>John J. Snyder</u> M.D. ADDRESS (Street, city or town, state) <u>6348 FREDERICK RD BALTIMORE MD</u> DATE SIGNED <u>20 MAR 1959</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 3-23-1959		22c. NAME OF CEMETERY OR CREMATORIALy			22d. LOCATION (City, town, or county) Lisbon, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. W. Waltz, Winfield, Md.					ADDRESS					24a. REC'D. BY REGISTRAR MAR 24 59	24b. REGISTRAR'S SIGNATURE Arthur S. Horne



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3004

## CERTIFICATE OF DEATH

102996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>53y 10m 18d</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>		f. STREET ADDRESS <b>Unknown</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bertie</b>		First	Middle	Last	4. DATE OF DEATH <b>Ricketts</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years from birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Ricketts</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Springfield State Hospital Record</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>(b) Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, hebephrenic type.</b>						Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <b>November 1, 1955</b> , to <b>March 16, 1959</b> , that I last saw the deceased alive on <b>March 16, 1959</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED <b>3/17/59</b>	
ACTUAL SIGNATURE <b>Elisabeth Knopp</b>				M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Elisabeth Knopp, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Director</b>		22b. DATE THEREOF <b>3-20-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sykesville</b>	22d. LOCATION (City, town, or county) <b>Sykesville, Md.</b>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bethel S. Height</b>		ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-request permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

102997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		d. STREET ADDRESS (Myers District) Westminster, Md. R.D.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster, Md. R.D.1 (Myers District)						e. IS RESIDENT ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILMA</b>		First	Middle	Last	4. DATE OF DEATH MAR 17 1959	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1920	9. AGE (In years last birthday) 38 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework		10b. KIND OF BUSINESS OR INDUSTRY Her own home		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Maurice Stuller		14. MOTHER'S MAIDEN NAME Blanche Stauffer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Stanley E. Selby, Westminster, Md. R.D.1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hanging</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>3-17 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		(City or town) Ri		(County) Littlestown Carroll Md (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James J. Marsh</i>		EXAMINER'S NAME (Type) <i>JAMES J. MARSH</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/17/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Littlestown, Adams Co., Pa. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard A. Little</i>		ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knau</i>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

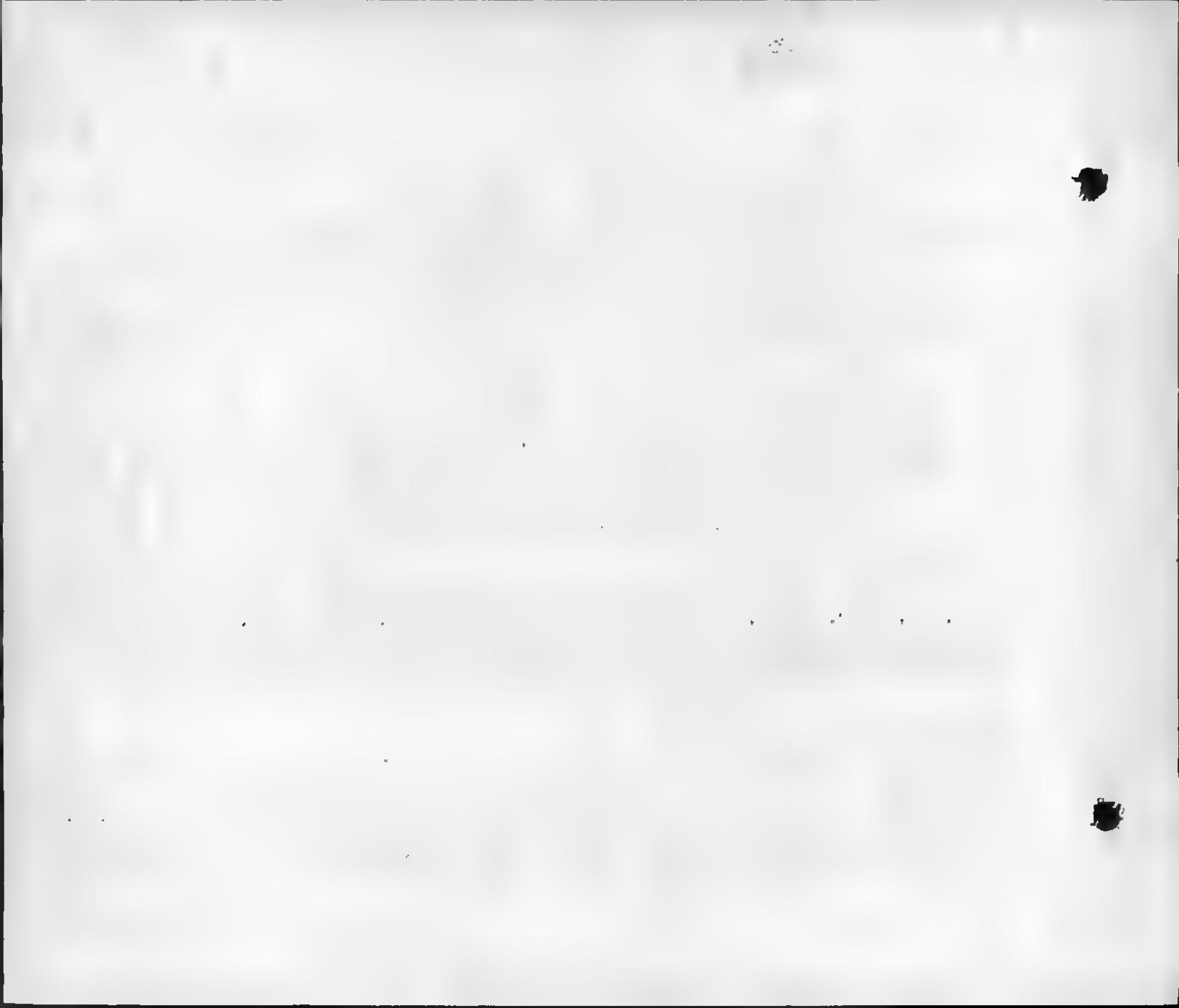
## 3006

### CERTIFICATE OF DEATH

02998

Reg. Dist. No.

PLACE OF DEATH o COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4yr 3mo6ds	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tacoma Park	
d. STREET ADDRESS 8624 Flower Ave		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First Elisabeth Middle		4. DATE OF DEATH Shenk <sup>lost</sup> Month March 21 Year 59 19	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-1884	
9. AGE (In years 1st birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? birth	
13. FATHER'S NAME Walker Pettie		14. MOTHER'S MAIDEN NAME Emma Hitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO unkn	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Coronary occlusion due to Infarction of myocardium weeks	
(b) Arteriosclerotic heart disease DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		years	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chr. Br. Syndr. assoc. with cerebral arteriosclerosis, with psych. reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nov 15 58		20f. (City or town) March 21 (County) (State)	
21. I certify that I attended the deceased from March 21 59 alive on 19		21. to 19 1:05 P.M. that I last saw the deceased from the causes and on the date stated above.	
ACTUAL SIGNATURE Konstantin Weber M.D.		ADDRESS (Street, city or town, state) Oak Str., Sykesville Maryland DATE SIGNED 3-21-1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Cana Memorial Cemetery		22d. LOCATION (City, town, or county) Towson, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Weber, 254 Anna St. N.E.C.		24a. ADDRESS 24b. REC'D BY REGISTRAR DATE MAR 24 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2, and be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3007

### CERTIFICATE OF DEATH

02999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Carroll, Maryland		53 yrs		Perry, Westmoreland		Carroll County Home					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		PERCY SHERPHERD		4. DATE OF DEATH		MARCH 10		Month		Year	
Carroll County Home		First Middle Last		1959		10		Day		1959	
S. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Not known		70 3 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?					
farm laborer for County Home				Anne Arundel Co., Md. U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
not known		not known									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		—		Carroll County Home, Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO General Debility											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Pericarditis of Lungs 1 yr											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
? 70											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ? 70									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from ? 1959, to 3-10-1959, that I last saw the deceased alive on 3-10-1959, and that death occurred at 3 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE W. C. Hayes		M.D. 3-10-1959									
PHYSICIAN'S NAME (Type) W. C. Hayes M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 12, 1959		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Cemetery		22d. LOCATION (City, town, or county) Westmoreland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westmoreland, Md.		ADDRESS		24a. REG'D BY REGISTRAR Date MARCH 13 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hayes					



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3008 CERTIFICATE OF DEATH**

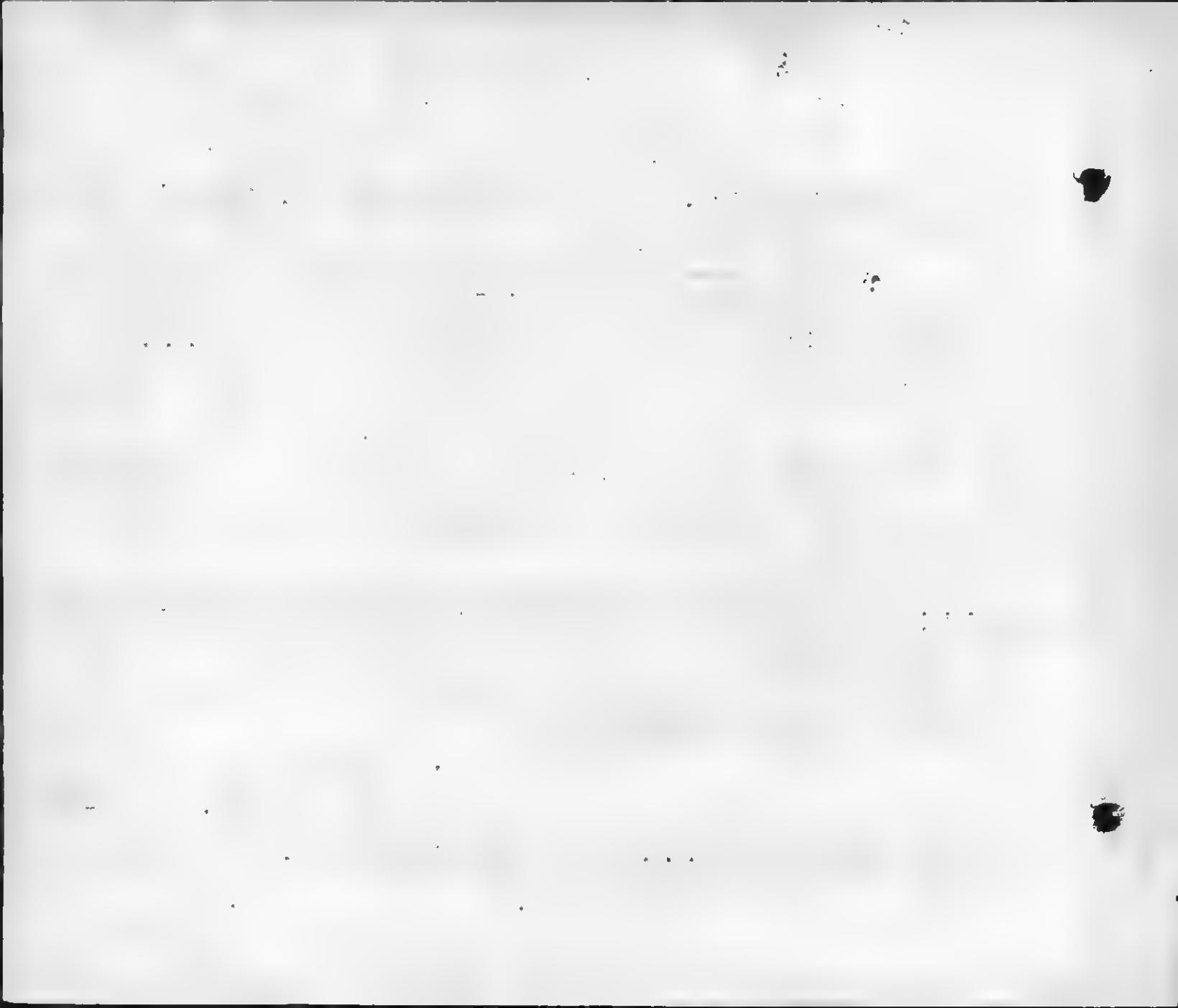
03000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>5 yrs, 27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Elizabeth</b>	Last <b>Smith</b>
4. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>9-16-71.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard Pardee</b>	14. MOTHER'S MAIDEN NAME <b>Mary Brady</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Hospital records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>  420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH years <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B. 5. associated with circulatory disturbances, with cerebral arteriosclerosis, with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March the 7, 1955</b> , to <b>March 15, 1959</b> , that I last saw the deceased alive on <b>March 14, 1959</b> , and that death occurred at <b>3:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) <b>M.D Springfield State Hospital.</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>3-15-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/18/59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cem.</b>	22d. LOCATION (City, town or county) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Sickner &amp; Sons - Baetz, Jr.</i>		24a. REC'D BY REGISTRAR <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Clara L. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

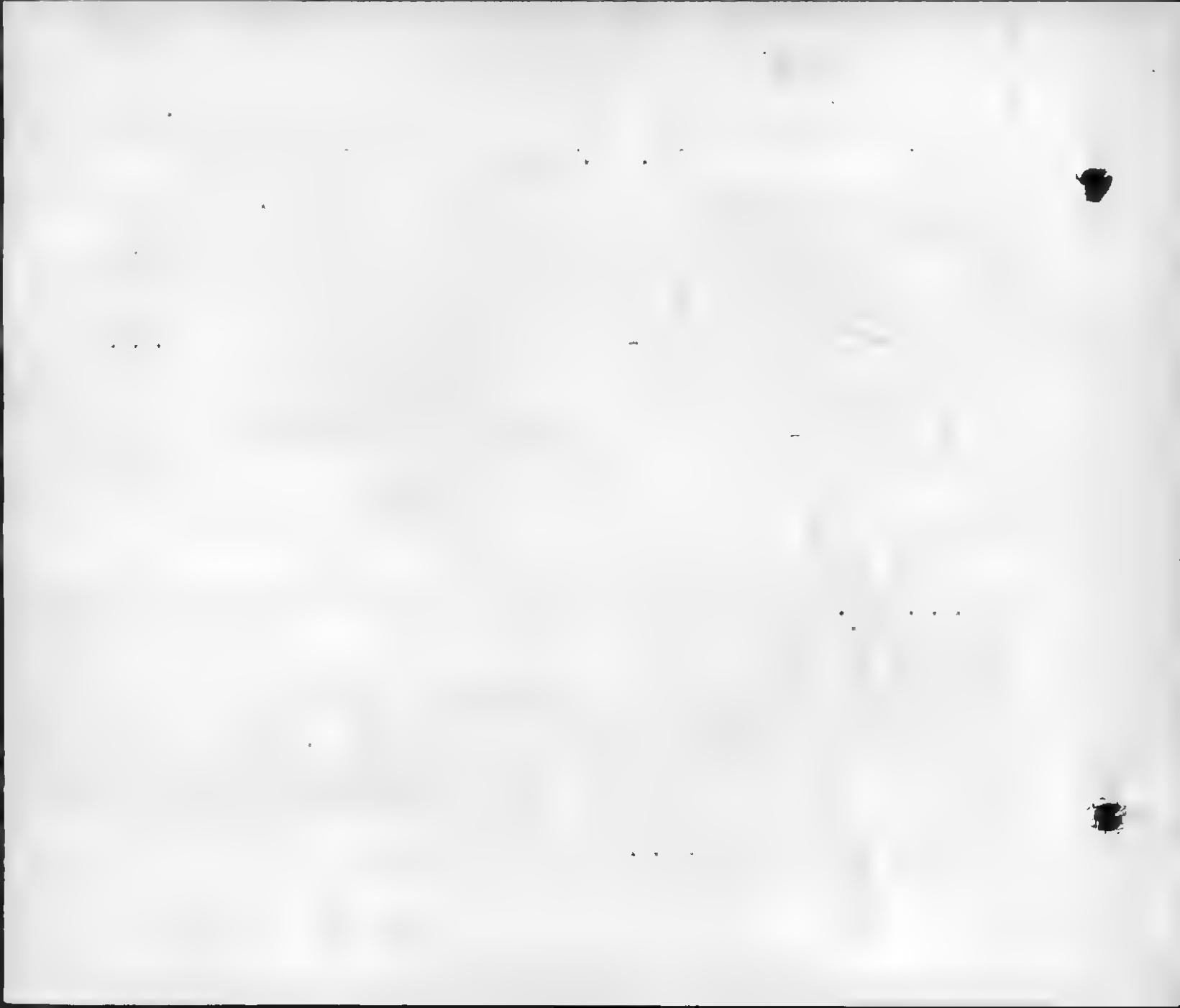
03001

## CERTIFICATE OF DEATH

Reg. Dist. No.

3009

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>lyr. 8mos. 5days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11</b>		d. STREET ADDRESS <b>3453 Chestnut Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Louvenia</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>March</b>	Month <b>31,</b>	Day <b>19</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1877</b>	9. AGE (in years last birthday) <b>81</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Payne</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lou Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>000 - 00 - 0000</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>420.0</b> (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH Years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with other than cerebral arteriosclerosis with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 26, 1957</b> to <b>March 31, 1959</b> that I last saw the deceased alive on <b>March 31, 1959</b> , and that death occurred at <b>11:10 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>3/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-3-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>LORRAINE PARK</b>		22d. LOCATION (City, town, or county) <b>BALTO.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Schenowitz</i>		ADDRESS <b>3617 Chestnut Ave.</b>		24a. REC'D BY REGISTRAR <b>APR 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Ciribus S. Frane</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

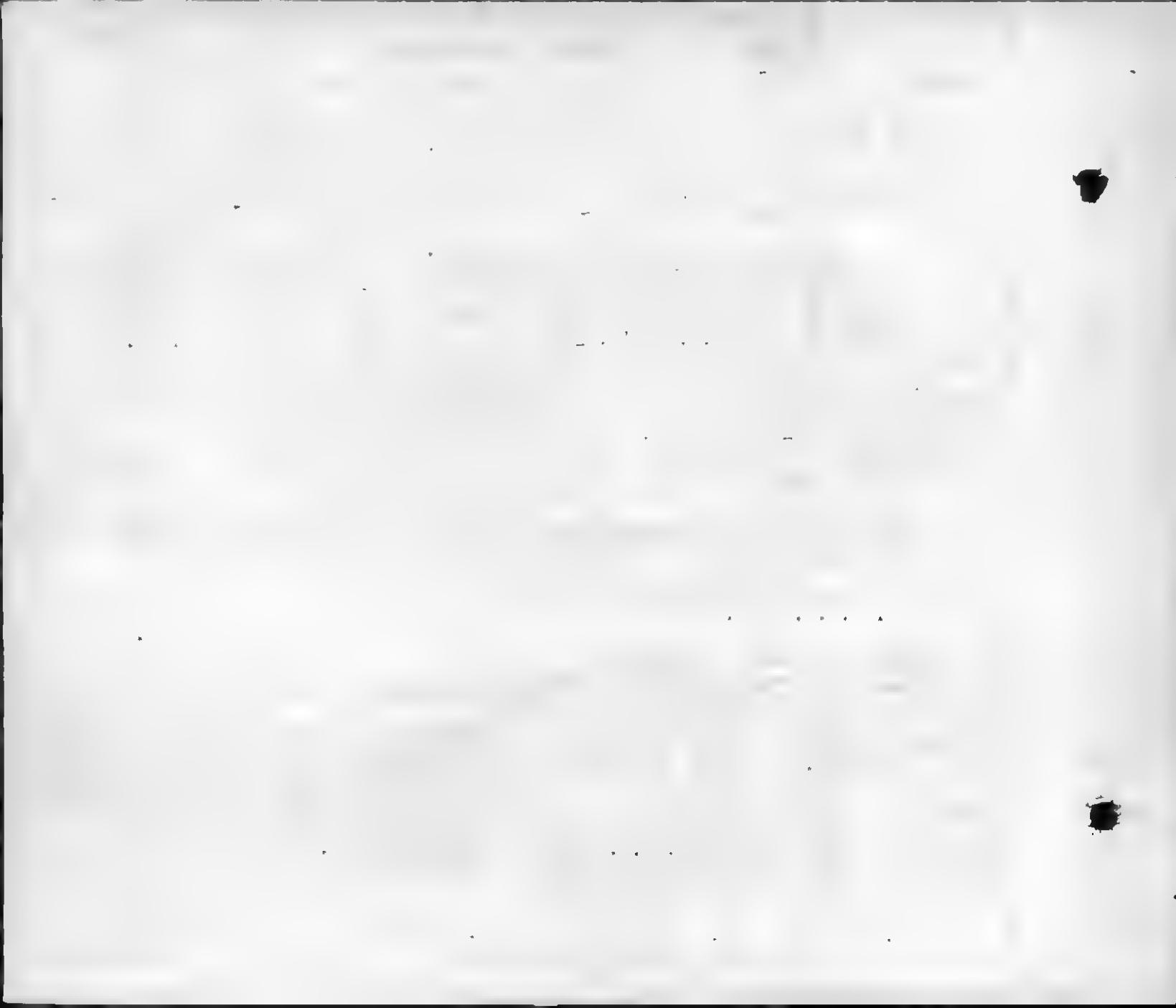
03002

3010

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>12825 Crisfield Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Harvey</b>	Middle <b>Wade</b>	Last <b>Solt, Sr.</b>	4. DATE OF DEATH Month <b>March</b>	Day <b>19,</b>	Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1891</b>	9. AGE (in years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book binder (Printing Office)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T. -</b>		10c. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		CARRIE DRYOR					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>YES -</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>									
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b>									
DUE TO									
(c)									
INTERVAL BETWEEN ONSET AND DEATH Years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes. C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>reaction.</b>							
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield</b>		(County) <b>Baltimore</b>	(State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>2/19/1959</b> to <b>3/19/1959</b> that I last saw the deceased alive on <b>March 18, 1959</b> , and that death occurred at <b>3:40A.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>									
DATE SIGNED <b>3/19/59</b>									
ACTUAL SIGNATURE <i>Agustin del Campo</i>		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) <b>MONTGOMERY COUNTY, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, Inc.</i>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D. BY REGISTRAR <b>MAR 20 '59</b>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03004

3011

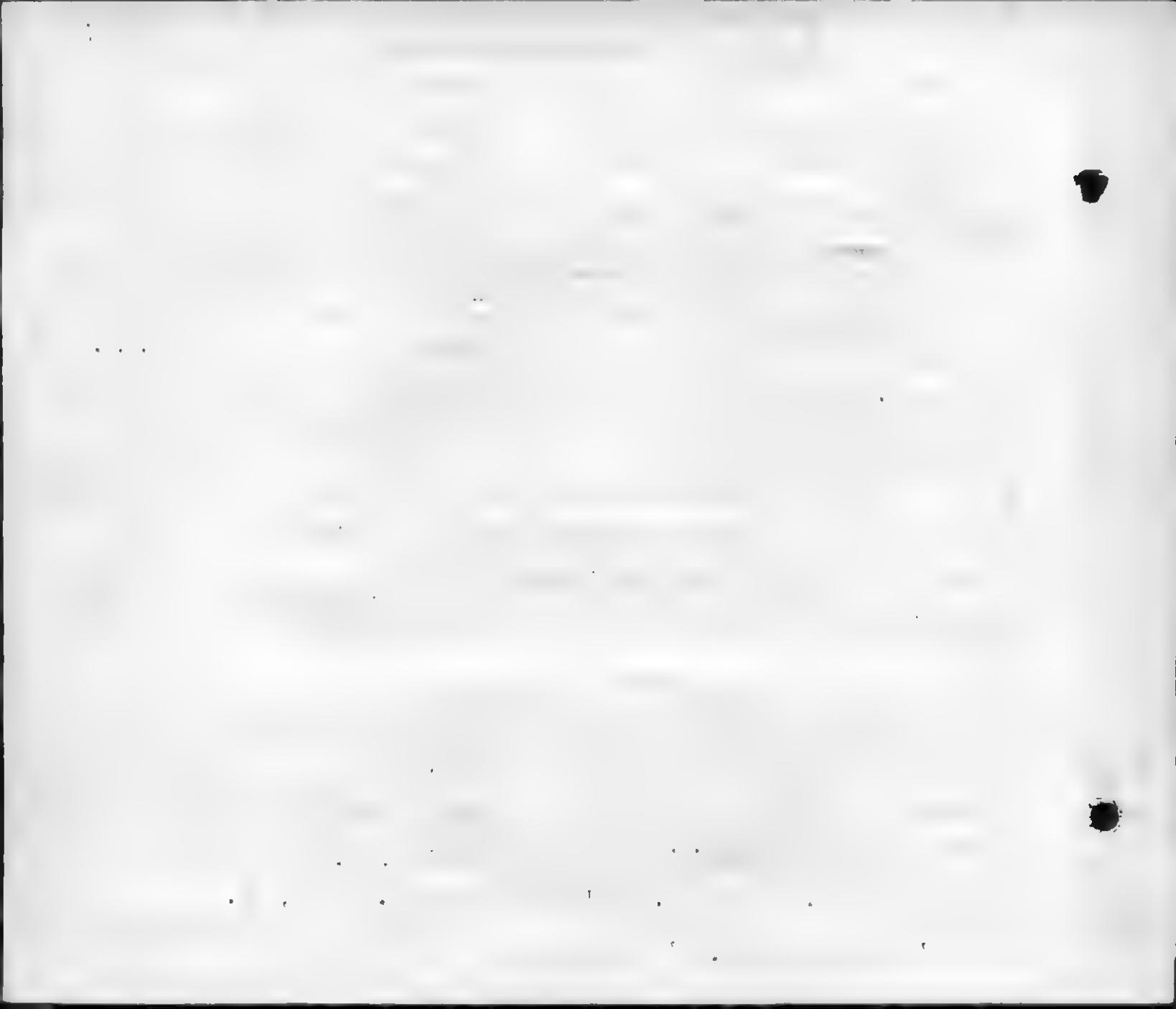
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>( Rural ) Sykesville</b>		c. LENGTH OF STAY IN lb <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		d. STREET ADDRESS <b>5816 Glen Kirk Court</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ARTHUR</b>	Middle <b>PETER GROMON</b>	Last <b>TURNER</b>	4. DATE OF DEATH <b>March 15 1959</b>	Month <b>March</b>	Day <b>15</b>	Year <b>1959</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-60</b>	9. AGE (in years last birthday) <b>78</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NON</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel W. Turner</b>		14. MOTHER'S MAIDEN NAME <b>Marilyn Loilla</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>/??</b>		16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>Springfield State Hospital ( Record ).</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO <b>4/2/61</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <b>Arteriosclerosis Cardiovascular disease</b> DUE TO				years	
		(c) <b>Cerebral cardio-vascular accident</b>				8 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with circulatory disturbances</b>		<b>cerebral arteriosclerosis</b>		<b>psychotic reactions</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Brief nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1, 1955</b> , to <b>March 15, 1959</b> , that I last saw the deceased alive on <b>March 15, 1959</b> , and that death occurred at <b>2: 12 PM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Walter Knopp</i>						DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mo. 17/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Catholic Cemetery, Laurel, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors,</b> 4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knapp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13005

3012

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>7mos.10days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 28,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>286 Rich Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b>Fred</b>	Last <b>Venis</b>	4. DATE OF DEATH <b>March 25,</b>	Month <b>March</b>	Day <b>25</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 30, 1872</b>	9. AGE (In years last birthday) <b>86 yrs</b>	IF UNDER 1 YEAR Months <b>86</b>	IF UNDER 24 HRS. Days <b>86</b>	Hours <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>4-11-11</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>460.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Generalized arteriosclerosis</b> (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchopneumonia; C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>						Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ADDRESS (Street, city or town, state)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Springfield</b> (State) <b>M.D.</b>	
21. I certify that I attended the deceased from <b>August 15, 1958</b> , to <b>March 25, 1959</b> , that I last saw the deceased alive on <b>March 25, 1959</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above ACTUAL SIGNATURE <i>Agustin del Campo</i> ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>3/26/59</b> PHYSICIAN'S NAME (Type) <i>Agustin del Campo, M.D.</i> Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Catholic</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) <b>M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Height (Sykesville, Md.)</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hansen</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03006

## CERTIFICATE OF DEATH

Reg. Dist. No.

3013

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 7days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		13.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Green	Last Warfield	4. DATE March	Month March	Day 30,	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1866	9. AGE (In years lost birthday) 92 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank employee		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph D. Warfield		14. MOTHER'S MAIDEN NAME Elizabeth - Young					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-14-1135		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)  DUE TO  C. b. s. assoc. with senile brain disease with psychotic reaction. (c)							
INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 23, 1958, to March 30, 1959, that I last saw the deceased alive on March 30, 1959, and that death occurred at 8:05 P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital DATE SIGNED 3/31/59							
NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/59		22c. NAME OF CEMETERY OR CREMATORIUM Damascus Methodist		22d. LOCATION (City, town, or county) Damascus, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McIlwraith		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDIN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103007

3014

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>19 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Taneytown</b>		d. STREET ADDRESS <b>Frederick Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Harry</b>	Middle <b>C.</b>	Last <b>Welty</b>	4. DATE OF DEATH <b>March 23, 1959</b>	Month Year 19	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1884</b>	9. AGE (In years last birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>James E. Welty</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Mort</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>220-16-4155</b>	17. INFORMANT <b>Howard Welty, Taneytown, Maryland</b>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion.</b>		DUE TO <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few Min.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b>		DUE TO (c)		<b>3 by 20.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>11/17</b> , 19 <b>56</b> to <b>3/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/20</b> , 19 <b>59</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>Taneytown, Carroll Co., Maryland</b>						
ACTUAL SIGNATURE <b>R. S. McNaugh.</b>	M.D.		DATE SIGNED <b>3/24/59</b>					
PHYSICIAN'S NAME (Type) <b>R. S. McNaugh.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 25, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Keysville Cemetery</b>	22d. LOCATION (City, town, or county) <b>Keysville, Carroll Co., Maryland</b>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merleyn C. Fuss</b>		ADDRESS <b>Taneytown, Maryland</b>	24a. REC'D BY REGISTRAR <b>Mar 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				
C. O. Fuss & Son								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03008

Reg. Dist. No.

2944

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Maryland</u>		d. STREET ADDRESS <u>126 Wempe Drive</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN lb <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gordon Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)	First <u>FREDERICK</u>	Middle <u>A.</u>	Last <u>WEMPE</u>	4. DATE OF DEATH	Month <u>MARCH</u>	Day <u>8</u>	Year <u>1959</u>
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1884</u>	9. AGE (in years last birthday) <u>74</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 MRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Wempe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Koelker</u> Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Francis P. Wempe, Westminster, Md.</u>			
17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>44-X</u> DUE TO <u>Cardiovascular cerebral disease</u> 4-5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Hypertension &amp; arteriosclerosis</u> (c) DUE TO <u>Hypertrophy Prostate chronic Gastritis</u> several yrs			
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 8, 1959</u> to <u>March 8, 1959</u> , that I last saw the deceased alive on <u>March 7, 1959</u> , and that death occurred at <u>Gizell M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. L. Scipper</u> ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>3/8/59</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Peter &amp; Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03009

3015

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>609 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>Route 2, Box 65A</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Andrew</b>	Middle	Last <b>Wessels</b>	4. DATE OF DEATH <b>March 6 1959</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-7-1888</b>	9. AGE (in years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Parksley, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi Wessels</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mary Hayes - Rt. 2, Box 65A, Eden, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>  002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Moderately adv. bilat. pulm. tbc., cavity rt.</b> DUE TO (c) <b>General arteriosclerosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 5 1957</b> to <b>March 6 1959</b> , that I last saw the deceased alive on <b>March 6 1959</b> , and that death occurred at <b>3:00PM</b> , from the causes and on the date stated above.		ACTUAL SIGNATURE <i>R. M. MacLans, M.D.</i> M.D. <b>Henryton, Maryland</b>				ADDRESS (Street, city or town, state) <b>Parksley, Virginia</b> DATE SIGNED <b>3-6-59</b>	
PHYSICIAN'S NAME (Type) <b>E. M. MacLans, M. D.</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sea Side Road</b>		22d. LOCATION (City, town, or county) <b>Parksley</b>		(State) <b>Virginia</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Sea Side Road</b>		22b. DATE THEREOF <b>3/11/1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sea Side Road</b>		22d. LOCATION (City, town, or county) <b>Parksley</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton E. Stewart</i>		ADDRESS <b>Silver Spring Md</b>		24a. REC'D BY REGISTRAR DATE MAR 10 '59		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03010

Reg. Dist. No.

3016		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
1. PLACE OF DEATH a. COUNTY	Carroll	a. STATE	Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY					
Sykesville	4 weeks	Carroll					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Springfield State Hosp	x At 4 Westminster Rd						
e. STREET ADDRESS	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Hines	Last Zeutz	4. DATE OF DEATH	Month 3	Day 8	Year 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/81	9. AGE (In years last birthday) 99 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Name		Frederick Co Md		USA	
13. FATHER'S NAME Levi Hines		14. MOTHER'S MAIDEN NAME Molly Lohr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		216-22-1623		Mary Fisher		Westminster Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Seizure Heart Disease 443X DUE TO <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH years</span>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congestive Heart Failure							
(c) Upper Resp Infection							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Chronic Brain Syndrome with Senile Brain Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3, 1959, to 3-8, 1959, that I last saw the deceased alive on 3-7, 1959, and that death occurred at 12:50 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		DATE SIGNED 3/8/59					
PHYSICIAN'S NAME (Type)		EDMUND LUSTHAUS Sykesville, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11-1958		22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cem.		22d. LOCATION (City, town, or county) Thurmont Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond & Creagan Thurmont Md		ADDRESS		24a. REC'D BY REGISTRAR MAR 1 0 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

WISCONSIN STATE GUARANTEE COMPANY  
CONTRACTS OF LIFE

